The role of hospital consultants in management, decision making and change

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THE ROLE OF HOSPITAL CONSULTANTS IN MANAGEMENT, DECISION MAKING AND CHANGE

submitted by Anthony White
for the degree of PhD
of the University of Bath
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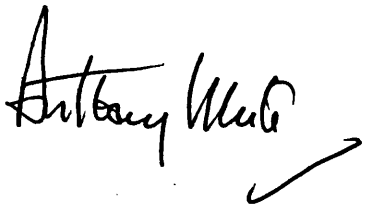

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SUMMARY

This thesis, using a methodology based on ethnomethodology or participant comprehension, has studied the role and involvement of the medical profession in the decision making and management of acute hospitals both within the NHS and within similar hospitals in the United States. It considers the management changes that have taken place in hospitals, and the involvement of doctors in management together with the effects on clinical freedom.

The philosophy of involving doctors in management is considered from the viewpoint of the medical profession and management, considering both the advantages and disadvantages, and the factors and influences which affect this within the context of existing clinical involvement in management.

The struggle for control and power between doctor and manager highlights the different characteristics of doctor and manager and their different educational, attitudinal and career backgrounds. A test of the relationship of two groups, both within and to the hospital, is introduced and discussed, as well as how that relationship is affected by the patient.

The management involvement by doctors and the problems this creates for managers and doctors and their future role is

followed by a discussion of the basic principles and structures of emerging clinical directorates, and the thesis suggests what the future might be for hospital organization, and how some integration might be achieved. The concepts and skills that are necessary for involving doctors in management are listed and finally some suggestions made for the direction of further work.

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Not least I am grateful to my wife Anne and my sons Simon, Daniel and Edward without whose inspiration, support, tolerance and encouragement the whole project would not have been possible.

CHAPTER 1

INTRODUCTION TO THE RESEARCH TOPIC

1.1. Introduction

The reforms of the National Health Service first published by the Government in its White Paper "Working for Patients" in 1989 had the declared intention of increasing involvement of clinicians in the management of resources, (HMSO, 1989:11); this document states:

> "It is therefore important that consultants are given more responsibility for their use of resources."

It also provided a stimulus for a more detailed investigation into the role of hospital consultants and specialists in the various processes of management, decision making and change in acute hospitals and health care organizations.

So I began with what at the time, seemed like a simple question:

> "What is the role of a doctor in managing a hospital"

This does in fact require qualification as to what is meant by "managing" a hospital. Although doctors are

responsible for most of the daily activity in the wards, theatres and outpatients, and therefore considerable expenditure, it can mean the running of the hotel and other similar day to day facilities and not just the purely medical aspect of the hospital. There are also some semantic differences in how the term is used, generally, and it is used differently in England and in America. There are all sorts of ways people run complex organizations and it was not long before I realized how very naive my original question had been.

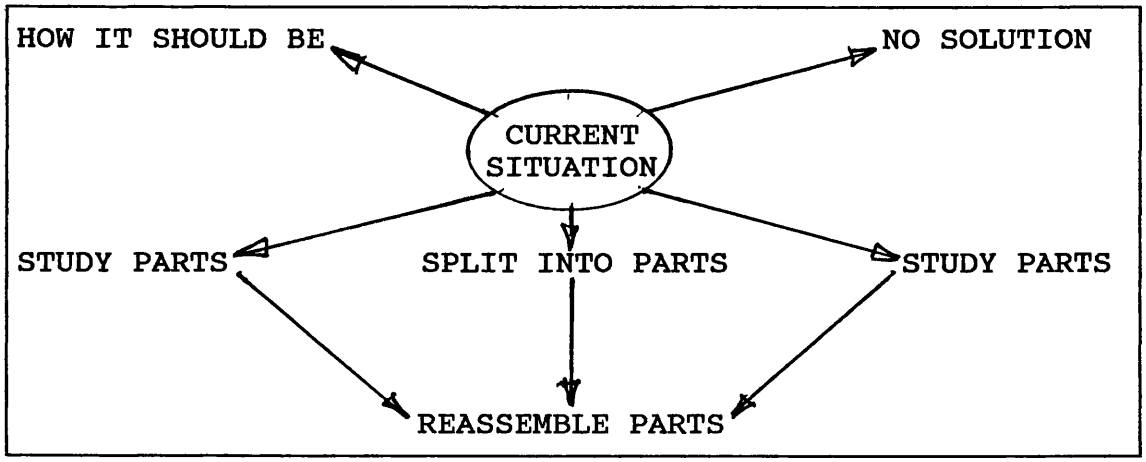
An initial year was devoted largely to background reading and considering the questions to be raised, much of which changed as the learning process evolved, a matter given detailed consideration in Part 5 Chapter 19 which details the personal lessons learned and my learning curve. During 1991 when fieldwork commenced there was a rapid and extensive change as foreground knowledge increased; this change continued and accelerated after interviewing more and more clinical directors, consultants involved in management, and general managers.

1.2. The method of the study.

It seemed in the early days as if the plan would be very simple and I considered several options as tabulated on the next page. Firstly I could consider content, the situation as it was, and what I felt that the situation

should be, in other words how it could be improved and which direction it should be going in. Then I could describe how it should get from the one position to the other. Alternatively I could take pieces of where it was, study them individually, see how each should or could be changed and then try and fit them all together again as a whole. Or, having considered the whole problem in depth, I might have to admit that there was no simple answer, and that I could find no solution. I felt that the answer and conclusions were unlikely to be simple. If they were then the thesis would be flawed as studies of this nature and depth, from what I had already discovered, do not come up with simple answers.

Study of "content" of the change.
(What changes).



Or I could study the process, the "how" and try and understand and explain the changes, the actions, reactions and the interactions of the various parties, in particular the consultants as they moved from its present state, to make a study of the doctors' reaction and involvement in the change process rather than the actual changes themselves, in order to see how doctors handled change.

Study of the "process" of the change.
(The How of Change).

REACTION TO CHANGE
INVOLVEMENT IN CHANGE
PROFESSIONAL CHARACTERISTICS AND CHANGE
MANAGEMENT STYLES WITH CHANGE
COMMITMENT TO CHANGE
ENERGY AND ENTHUSIASM FOR CHANGE
MOTIVES FOR INVOLVEMENT IN CHANGE

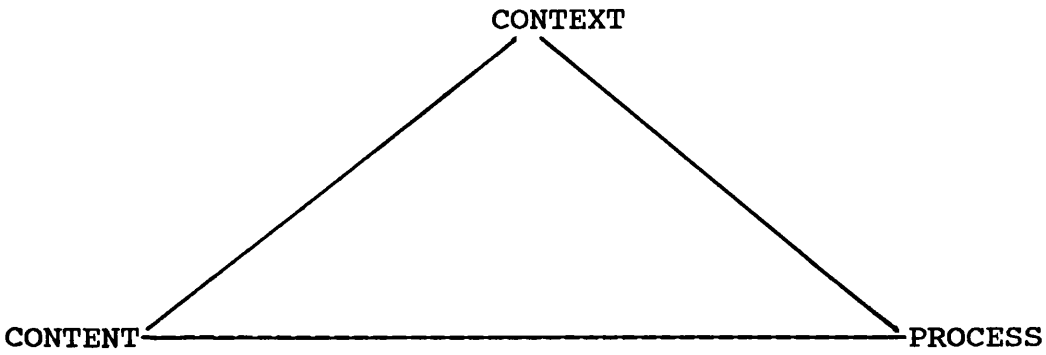
Or thirdly I might study the context of the change, the "why". Pettigrew (1985a, 1985b) and Pettigrew, McKee and Ferlie (1988) relate all these three areas of context, process and content, but also point out that analytically context is divided into an outer and inner context;

> "Outer context refers to the national economic, political, and social context for a district as well as the perception, action, and interpretation of policies at national and regional levels in the NHS. Inner context refers to the ongoing strategy, structure,

culture, management and political process of the district which help shape the process through which ideas for change proceed."

And the extent to which I have considered this is referred to later in this chapter (section 1.6.7) under Other Influences.

Pettigrew et al (1988) summarize the three approaches diagrammatically:



They continue by describing how neglect of context and the role of powerful groups within them has produced a situation in which myths abound, and they continue;

"Rather changes are also a product of processes which recognize historical and continuing struggles for power and status".

1.3. The Scope of the Study

In my research I have studied the role and the involvement of the medical profession in the decision making and management of acute health care organizations particularly acute hospitals both within the National

Health Service in England and also within similar organizations in the United States.

This has involved studying Clinical Directors, General Managers and Chief Executive Officers, Chairmen of Trust Boards of various hospitals , and also Academics, Governmental Medical Officers and Health Economists primarily through interviews and discussions. In addition I have attended Management Board Meetings and Medical Executive Committee Meetings of the various institutions to study how the doctors and managers handle the decision making and management processes that go on within the hospitals. The Academics, Governmental Medical Officers and Health Economists have enabled me to step outside the immediate environment of a hospital as a unit and study the institution as part of a greater organization, and to relate the changes that occur within a historical, environmental, sociological and political context.

Clinical Directorates as a role model are said to have originated in Johns Hopkins Hospital in Baltimore, (Disken, Dixon, Halper, and Shocket, 1990:3) which is often cited as the model for ideas in the White Paper. I thought it would be very relevant to this study to consider the American experience. In addition America was introducing clinical outcomes audit in 1973, a concept

also introduced into the U.K. with the White Paper. (HMSO, 1989).

Years ago America realised that the cost of health care "far exceeded" the "willingness" of the public to provide the necessary finance (via in their case the insurance companies and employers), (Bailey, 1990) (Friedman, 1991) (Holahan, Moon, Welch, and Zuckerman, 1991). This led to the introduction of various concepts of limiting costs by involving doctors in the decision making processes to allocate resources. (Heyssel, Gaintner, Kues, Jones, and Lipstein, 1984).

Also until 1990 most of the useful writing on doctors in management had been written in American Journals. (Rubin, Plovnick and Fry 1974), (Rubin et al, 1977), (Weisbord, 1976), (Blumberg, 1977), (Kouzes and Mico, 1979). The Americans had for instance long realised that management methods no matter how valuable in other settings, do not work well in medicine, because they feel that medical centres have few of the characteristics of industrial firms. There also appeared to be a greater willingness on the part of American doctors to be involved in administration and management in hospitals and departments, greater co-operation between managers and clinicians and greater incentives to provide a constantly improving service for the benefit of all, and a greater sense of immediacy in solving problems. As one Executive

Vice President and Chief Executive Officer of an American Non Profit Hospital put it to me,

> "I think it's important for managers to be objective, to be open to physician comments, to spend a lot of time out in the hospital, because I think that the lack of availability sometimes on the part of hospital managers and senior managers is what creates that scepticism among the medical staff, "these people don't know what the hell they're doing, because they don't know what we do. So how can they control what we're doing from an office that is so far removed from hospital activity." Likewise I also wear this, beeper, and the reason for that is that I tell my secretary that in the event a physician calls my office, for whatever reason, if I'm not here, beep me, if I am here, interrupt me. So that I think that availability is very important for physicians, for as you know, physicians work (at least when they're in the hospital), in an acute setting, and when things need to happen in a very timely fashion, they call. I think they sense a lack of interest or desire in really resolving their issues. You can resolve many things in a two minute telephone conversation that can take a month, if you don't address it at that moment."

1.4. The Changing Environment.

One of the issues that caused me some concern initially was the speed at which the subject under study was changing. The reforms of the White Paper (HMSO, 1989) "Working for Patients" are more radical than anything that had gone before in the National Health Service. I was concerned as to the point at which I should draw a line, describe the scene and draw some conclusions, rather in the manner of a giant painting a mural depicting some great event in history.

This is a subject already discussed in section 1.2 and to which I return further in Part 5, Chapter 19. Suffice to say that in a changing scene, I was studying as much the process and context as the event. My first hypothesis was quickly overtaken by my new learning, my initial overall plan became meaningless, the variables changed and the relationship between them also changed. The methods of data collection had to be adjusted to accommodate this, and even my advance plan for data analysis had to be refined to match the quantity and type of data I was collecting. My scientific training initially proved a hindrance as it was inappropriate to the task of social science research. I felt I was researching with an emphasis on discovery, rather than with an emphasis on proof. I shall return to the actual methodology in Chapters 8 and 9. What was certain was that my initial learning process and change in attitude had to be fairly rapid.

1.5. The Research Process.

The process of the study could be described as iterative and enfolded. The process was not a linear one of a gradual development or even a conceptual leap into an idea, which was then tested and the results reported, in the way my training was encouraging me to go. Rather, it was periods of exploration alternating with periods of theorizing and reading the ideas of others in the

literature then trying out and exploring new ideas with the interviewees to see how they developed. Then I had to return to the literature to follow up loose strands, queries and new thoughts that had been thrown up by my experience.

Thus the knowledge I have acquired has grown by an accumulation of experience and experimentation, as well as the views, philosophies and ideas of others, and my maturation, of which the writing of this thesis is itself a part. The thesis is therefore a guide to how I have arrived at the body of knowledge I have acquired as well as an attempt to document those findings. There is a slight mixture of literature, method and findings throughout, which I shall refer to at the beginning of appropriate chapters, although I have tried to separate these into various sections as appropriate. Part 2 covers the outline and background of existing knowledge. Part 3 is an explanation of the methodology used. Part 4 concentrates largely on the data and findings with some discussion and Part 5 draws it all together with further discussion and suggestions for the direction in which the work should be continued.

1.6.0. General Plan of Work

1.6.1. Historical Background

I have begun by considering the historical background to the control of doctors' work in hospital, how hospitals were administered, by whom, and how this has changed over the years and in particular since the beginning of the NHS. At the same time a parallel with the USA experience over the last fifty years will be outlined. The introduction of professional management into the hospital structure will be considered, including whether this was the result of apathy for the role by the medical profession, an act of deliberate policy by the government or a matter of expediency by government and managers.

There has been a considerable volume of literature on the doctor's role in the hospital and considerably more on Organizational Development, but little on the role of doctors in a management capacity in hospitals. There is a growing literature (Bennett, 1987) on the "medical culture" and the combined effect of medical training and socialization on the attitudes and behaviour of doctors which has created problems for doctors in relation to managers and management.

Sociologists and psychologists have studied the institutional role of a number of occupations and

professions. And the amount written on management has been vast. But doctors and their role in management has rarely been the centre of this research, although it seems obvious that their role is central to the issues of management of a hospital. Fitzgerald and Sturt (1992) say,

> "There is limited research evidence on clinical management roles or their operation in the UK. A literature search of current articles yielded only five items on clinician managers. Yet the trend towards establishing clinical directorates and clinical directors as clinician managers has accelerated dramatically."

Most observers have suggested that the basic problem in researching this field, (which I discuss in the next section), is one of entry of "outsiders" into the medical "world".

1.6.2. Entry problems.

The medical profession have in the past failed to be convinced of the value of the social science research; doctors feel defensive about non-medical researchers delving into their work and behaviour, and they think that it might invade the ethic of confidentiality. One doctor put an issue to me thus;

> "Now I would have to word that much more delicately to non doctors, and I probably would not have said it."

They are of course a very conservative group and many fear change. Griffiths (1992b) says:

> "We also have to remind ourselves continually that the medical profession is conservative and does not like being assailed with new global theories, particularly economic theories, which they generally regard as less proven than even alternative medicine."

And Cartwright agrees (1977:184):

> "Some would blame the senior doctors holding that they are too conservative, unwilling to move with the times."

Several Clinical Directors reminded me of consultants' fear of a hidden agenda in any research or review of their work that might affect their income and prestige, by altering the mystique of the present system. As one Clinical Director said:

> " And those physicians in specialties whose incomes have dropped recently, tend to be the most vocal."

It is also traditionally and frequently indicated that they are very busy, and time is a valued professional commodity. I therefore entered the research with something of an advantage, not only as a member of the medical profession, but also as a surgeon, which some regard as the most prestigious part of the profession. The issue of a pecking order within the profession is again an issue which will appear from time to time in further chapters. I had less trouble therefore in

obtaining interviews with consultants in hospital, even surgeons! I was able to handle the scepticism, even scorn, of some of them at the idea of a social science research project using post positivistic methods.

Because of the number of interviews four were conducted by a research assistant, herself a trained counsellor who therefore has extensive experience of handling interviews. Her experience was somewhat different. One Clinical Director approached to participate declined to be interviewed, one was not available when she arrived, and one was mildly hostile although he knew in advance what the questions were going to be. This could be because, firstly, she is female and even now the medical profession is male dominated. They could have been uncomfortable because she is not a doctor or because since they didn't see the researcher their own status was somehow reduced.

1.6.3. Organizational Development Theory

I then considered the theory of Organizational Development in Human Service Organisations. A vast descriptive literature of health organizations exists. On the other hand there was little practical guidance on how to use this knowledge effectively (Weisbord, 1976). This is surprising when over a decade before, Vinter (1963) wrote that extension of organizational analysis into the

health and welfare field has been extremely limited. He suggested that the knowledge, if acquired, would permit deliberate redesign of organizational conditions to achieve more effective services. Most of the literature is found in books and journals from the United States of America, so that this does bias the work to that side of the Atlantic, but it did make it more important that I consider the problem of consultants in management in American hospitals as part of the total investigation.

It is a popular notion that there is a common failure of hospitals, compared to other service institutions, to perform well. Explanations are, that the organization or its managers are not business like enough, that hospitals need better managers and that the objectives and results are intangible. Drucker (1977) feels that this belief underlies the management boom in service institutions. He attributed the explanations to alibis rather than explanations. He also believes that business-like in a service institution means primarily control of cost, he feels that effectiveness and not efficiency are what the service institution lacks, so the basic problem is lack of effectiveness. He also feels that the objectives of the business of a hospital are tangible, that is they have to satisfy not only the patient, but also the doctors, the nurses, the technicians, the patient's family and the taxpayers etc.

The cry for better people is something echoed in the earliest Chinese texts on government. It is absurd to expect the administrator of every hospital will be a genius. Indeed Drucker (1990) feels that what matters is not the leader's charisma but the mission. The first job of the leader is to think through and define the mission of the institution. He stated,

> "that leadership by itself is not enough, that it's an end. And that's misleadership".

1.6.4.0. Data collection

Before discussing the details of the data collection it might be helpful to give some broad outline of the scope and size of the project. I interviewed 60 NHS consultants involved in management as clinical directors and 18 General Managers or Chief Executives. These doctors and managers came from 13 NHS hospitals, some Directly Managed Units and other independent Trusts which were seeking and have since been given independent Trust status. They ranged from a major London teaching hospital to a small District General Hospital. In addition I interviewed 10 health care academics, many of whom had been general managers or consultants previously, 7 Regional Officers and 2 Governmental Officers.

In the United States I interviewed 27 doctors involved in management and 13 hospital administrators at 6 hospitals,

from a major University teaching hospital through a Veterans' Administration hospital, a Community Hospital and a Private Not for Profit Religious Institution.

The total number of interviews was 118 and the total number of hours interviewing in excess of 200 hours. In addition I attended over a hundred hours of meetings over and above the meetings I attended and studied within my own hospital, part of my normal work as a practicing clinical director. There were over 300 hours of tapes transcribed and the transcriptions of important sections of interviews and notes from interviews and meetings has come to more than 500,000 words.

In addition I held seminars and workshops for doctors involved in management and for managers, with all the discussions and feedback sessions recorded; although they were not transcribed I did have the opportunity to play them back several times and make notes.

While covering statistics it might useful to conclude this section by saying that the project involved reading 124 textbooks and 25 official NHS publications, as well as 1,180 published papers and articles, 198 of which I found important enough to photocopy, 92 on organizational development, 42 on clinical directorates and 64 on the NHS in general.

1.6.4.1. General Principles

There were many different ways I could have approached the problem. I planned a systematic analysis of organizational and management literature on this and other sectors, as well as a search through the literature on the historical, sociological and political background, with particular reference to the origins, course and future of health services. Because there were close links in the recent reorganization of the National Health Service with American experiences and expertise, some comparisons between the one health system and the other were necessary. I considered that epidemiological and economic research into the costs and effectiveness of different methods of running health care were however, outside the scope of the project.

Above all this is an ethnographic study. A variety of ethnographic studies of, for instance, the Griffiths (1984) reorganization have been undertaken, for the technique is now used by many different disciplines and in many different ways (Cox, 1990). The method is said to stem originally from anthropology (Diesing, 1977:5) but has close parallels with some of the methods used by social historians. Both sorts of research aim to study thought and belief and the way these relate to human action. One question remains however: how can this be done when some thoughts and beliefs may remain unsaid,

and some may be deliberately concealed, even if much is spoken or written down? This is an issue addressed in more detail in Chapters 8 and 9 on Methodology.

Most of this study sets out to capture speech rather than the written word. To do this, I have conducted in depth informal interviews with people directly involved, doctors as Clinical Directors or Medical Directors, Nurse Managers, District and Unit General Managers and Chief Executives, Presidents, Directors of Finance and Personnel, and with the Chairmen of Health Authorities and Trusts, governmental doctors, and departmental medical officers. The latter was largely the result of my trying to interview Ministers from the Department of Health who, like their colleagues in the shadow departments in opposition, all refused to acknowledge let alone reply to my many letters. In addition I interviewed and discussed my ideas with health academics and health economists.

I have sat in on internal health service management meetings and attended conferences of doctors and managers. The NHS is a vast organization and ethnography is an intensive method. Although I wished to portray the whole, the amount of data was enormous. I was therefore forced to be somewhat selective. (Though the data on the problem was gathered from many different levels). I

focused my main efforts from time to time on the areas which gave me most difficulty at that particular moment.

I have looked across to other districts and hospitals, concentrated on individual hospitals and clinicians, but I have also been up to the tiers above, to region, and beyond, to Whitehall. General Practitioners are not forgotten though not much mentioned in the study. Until the reforms it would have been hardly necessary to consider them in the problem, but since the reforms of 1989 they have become a factor, particularly those who are Fund Holders. It is very much an investigation about people trying to cope with, understand and implement change.

After the first background chapters, much of the rest of the work is in the words of the interviewees. Their speech is set inside an analytic framework which I have provided but the main evidence for the arguments comes in quotations to illustrate a point. Since almost everyone spoke so frankly, I have omitted names, and changed what identifying details I thought necessary. A similar blanket of anonymity covers the hospitals and districts.

1.6.4.2. Details of Data Collection

The data on the project was originally to be collected from doctors involved in management decision making and

change in hospitals and from senior managers. Initially the questions were mine and the whole data collection was based on using intensive, loosely structured interviews. The subjects were all volunteers from an institution, approached initially through the Unit General Manager or Chief Executive Officer.

In the introductory letter an outline of the research project was given together with a request to interview not only the Unit General Manager or Chief Executive Officer but also another senior manager and at least two hospital consultants involved in the management of the hospital. Ideally this included the Medical Director and a Clinical Director sitting on the Management Board or equivalent.

Some hospitals found fourteen such volunteers, at Stanford University Hospital I interviewed six senior managers including the President and eight senior consultants involved in the management of that institution. At others I interviewed only the Chief Executive, and only one Clinical Director was forthcoming. On the whole the North American hospitals were far more willing to participate and take the subject seriously than were the English hospitals.

In England about a week ahead of the interviews the subjects were given a list of topics covering no more

than half an A4 sheet. This was not possible in the United States as all the interviews were arranged by the hospital and I did not know until I arrived who I would be seeing. The interviews were planned and I requested that they last about an hour, the participant being allowed to talk freely about the subject in any way they chose. The interviewee having being given an estimate of the length of the interview in advance, was free to continue if they so wished for as long as they needed. The shortest interview was about twenty minutes and the longest four hours.

The technique was to use reflective listening and only interfere with the subject's discussion if it should drift well away from the topic. All interviews were recorded with the permission of the interviewee, who had been warned in advance in the original letter to the hospital. Only one English Clinical Director felt unhappy about the tape recording but in subsequent correspondence felt that he had not been inhibited in answering the questions. Notes were taken of the main points raised and used as a personal aide memoire to raise further queries later at the end of the interview. They were also useful in drawing out organizational and management structures, to which reference might be made during the discussion. After the interview a recording or further notes were made of my immediate post interview impressions and including any remarks made by the

interviewee after the main recording had been finished. The two recordings were transcribed and these, together with the notes, were used to construct a summary of the main points covering no more than two sides of an A4 sheet. This was posted to the interviewee who then had the opportunity to change anything which had been misunderstood, correct anything said in error, or add any additional thoughts. This is a technique based loosely on a method described by Simendinger and Pasmore (1984) which is felt to provide more information regarding respondents than other more general interviewing methods.

Factors discussed include the practical aspects of managing, and the relationships between doctors and managers, including preconceptions and experiences. I also explored my subjects' vision of future developments. In general doctors and managers agree about more things than they disagree on. Also relationships between them tend to improve or deteriorate on stereotype beliefs of one another, rather than accurate views of each other.

As stated above the original questions were mine but this is a research based on "co-operative inquiry" and this is discussed in detail in Chapters 8 and on Methodology. As a result the research, and in particular at this stage, the questions, changed and adapted to the participants feelings and views of what were or were not important. Indeed this has been a constantly evolving process.

1.6.5. External Data Collection.

By this I mean the data introduced by the main players and it has four main pillars: Date gathered from doctors and managers, both from the U.K. and the U.S.A. I then introduce the data to initiate a discussion on the changes which have taken place in the consultant's role and predict where they are going, with some views as to how this may change and develop in the future. This has been fulfilled largely and has lead to some suggestions for changes in the methods of managing hospitals.

1.6.6. Internal Data Collection.

This studies the actual working of the various hospital committees on which consultants and managers meet to inform, discuss and decide issues, and which are part of the management hierarchy and structure of the hospital. On some committees I sit as chairman, others as a participating member and others merely as an observer. Other members of those committees have been interviewed about their views and actions.

1.6.7. Other Influences

There have been other matters to consider which I collectively call "other influences". I have tried to

view the management role of consultants not in a narrow sense confined only to the local district hospital, but also to study them as a group, with a major influence on the actions and activities of the medical profession as a whole, whether that be at district, regional or national level.

To broaden and raise my vision I also sought the opinions of researchers and academics in independent health care research organizations such as the Inter Authority Comparisons and Consultancy part of the Health Services Management Centre at the University of Birmingham, The Kings Fund Centre and The King's Fund College.

As a result of one of the interviews with a Fellow of the King's Fund College I was given the opportunity to speak at a King's Fund course on Resource Management for Clinical Directors. The discussion which followed lasted long after the planned time to finish, and gave me a valuable feedback from a group of nearly twenty consultants who had not previously been involved in the project.

In the American Hospitals I studied University Hospitals, Private Hospitals, Community and County Hospitals, Veterans Association Hospitals and Non Profit Religious Charity Hospitals. In England all the hospitals were part of the National Health Service, and to reveal any

possible different perspectives I did include interviews with two private hospital managers, as well as the Medical Director and Managing Director of the British United Provident Association.

1.6.8. Human Service Organizations

I had also planned to interview the heads of some other HSO's to see whether the similarities and grouping of hospitals with HSO's was valid and whether lessons could be learned from them for transfer to the hospitals. Although I did carry out one interview with the headmaster of a large comprehensive school, and I could see it was a field where there might be some interesting and useful research, I abandoned this aspect as other lines of inquiry began to yield such large quantities of data that I was in danger of being swamped. In addition the work itself led to more suggestions and invitations to pursue the interviews at national level, providing information directly related to the original theme of my inquiry.

1.7. The Contents of the Thesis.

There are several sections to the thesis. In part 1 I introduce the work, "the problem", and the purpose of study and consider some problems of validity. This is followed by a general plan of the work.

In Part 2, there are five chapters reviewing the literature and considering in detail some of the major issues. In Chapter 2 the changes in the National Health Service and its organization and reorganizations are related to the involvement of doctors in management. Chapter 3 describes how doctors came to be involved with hospitals. Chapters 5 and 6 consider the whole question of clinical autonomy or clinical freedom as it is now known, and its consequences.

Part 3 consists of three chapters, chapter 7 discussing both validity and bias. The following two chapters consider the development of the methodology, the theory and choice available in chapter 8, and how the decision was reached in chapter 9.

Part 4 introduces most of the findings. It is divided into seven chapters considering various models of clinical management and doctors in management roles. There is consideration of the management views about this issue and the relationship between doctors and managers. Then the last two chapters in this section consider the issues associated with managing as a Clinical Director and how doctors can be introduced into management.

Part 5 is the conclusions with the lessons learned, the possible future, a suggested programme of action, some

personal lessons learned, and finally some unanswered questions and suggested ways of taking the research on further.

1.8. The Literature or Existing Knowledge.

The process of exploring the literature began with a catholic and avid interest in anything that might be relevant. At that time, in the autumn of 1988, there was little of direct relevance, or so it seemed; my view of that has since changed but it is a statement, still germane. I can now refer to the literature more selectively, as I know which areas are useful and can significantly contribute to my investigations. I learnt much from the experience and writings of others and gathered many useful ideas. I suspect all are not being attributed, as sometimes I saw no connection with my work until days or weeks later, when an idea would spring to mind or a connection would be made, yet the origin would be obscured by time.

CHAPTER 2

CHANGES IN THE NATIONAL HEALTH SERVICE

2.0. Introduction

Change in health care provision is not new; although the inception of the NHS in 1948 was a major change in the provision of health care in this country, it has since been in a constant state of evolutionary change. The formation of the NHS however was not the end of this change process. The DHSS (1972) published a paper for reorganisation implemented in 1974. Six years later the DHSS (1980) published a further paper and in 1982 another reorganization took place. The following year the Griffiths Report DHSS (1983) was published and implemented the following year. In 1989 the government published its White Paper, "Working for Patients" HMSO (1989), introduced during 1991.

According to Welborne (1990), all organizations are now experiencing very rapid and continuous change and he feels that it is important for all senior staff and managers to develop skills to manage such changes if they are to be effective in their jobs. But this is not a new experience; as long ago as 210 BC Petronius Arbiter said:

> "We trained hard-but it seemed that every time we were beginning to form up in teams we would be reorganised.

> I was beginning to learn, later in life that we tend to meet any new situation by reorganising; and a wonderful method it can be for creating the illusion of progress while producing confusion, inefficiency and demoralisation."

2.1. Reasons for Change

These changes also beg the question as to their purpose. Is it to make the service better, and in what way? To treat more patients, or to treat patients quicker, or to treat patients for less money? Improvements in priority group services are often now financed through cost improvement achievements or rationalization within the acute sector. The government appear to see change within the NHS mostly as a means of cost improvement and cost containment. In a sympathetic review of the NHS, Enthoven (1985) notes the tight limits under which the NHS operates and considers that it will find it increasingly difficult to meet the demands placed upon it, so that it will need to find ways of obtaining even greater value for money.

Change has not only been concerned with finance, but also with management and control. In spite of talk of decentralization, the period from 1982 has been a time when central government has tightened its "grip" on the NHS through such reforms as annual review systems, the application of performance indicators and trial management advisory schemes. Petchey (1986) describes an

increasing disquiet, felt not only in government and the DHSS, but also by staff within the NHS, particularly doctors, about the failure or shortcomings of consensus management which he says,

> "were experienced as cumbersome and time-consuming, leading to institutional stagnation and creating a lack of managerial accountability."

Although the assumption that consensus management may lead to institutional stagnation may be difficult to justify, he does not elaborate on this aspect.

The early reorganisations recognised that the NHS is a loosely coordinated system. During the Royal Commission on the NHS, Kogan (1978) echoed the DHSS statements from 1972:

> "it is generally held that decision making cannot be undertaken by a Chief Executive of a single authority because of the integrative complexity of health care provision."

Schulz and Harrison (1983) claimed widespread support for the practice of consensus decision making as a means of managing the service.

2.2. Rewards and Incentives

The lack of adequate reward does not help. In private industry there are cost of living and merit based pay

increases for employees. During pay restraint, private organisations can manipulate the system to non cash benefits to reward their employees. Public service organisations have none of these advantages and are usually made to set examples of government pay policy norms. In a review of the incentives and economic efficiency of the NHS Enthoven (1985) says:

> "-the system contains no serious incentives to guide the NHS in the direction of better quality care and service at reduced cost. There are not many rewards for the manager who takes risks and makes the extra effort, and not many rewards for him or her to hand out to staff."

Rewards are more than the ability to recruit the right calibre of employee or reward effective performance, they are also a measure of the value that an organisation places on its employees and an expression of the value placed on them by society. To maintain, as governments do, that vocational reward is compensation enough for low pay compared to those in private industry may insult your employees. Estimates suggest that up to 10% of medical graduates never practice and a similar number drop out in the early years. And there is a growing tendency for medical consultants to take early retirement. In addition large numbers of nurses once trained never work, or, they do not return to NHS hospitals. Increasing NHS defections highlight a growing gap between the philosophy of the NHS and that of the outside world. Companies appreciate that

staff are an important and increasingly scarce resource, so they provide decent facilities to retain them.

For a health service to be effective it has to have some inbuilt slack capacity. This may be regarded by some as inefficient, but patients do not fall ill or have accidents at a steady daily rate. If there is a major disaster the local hospital(s) cannot say, we can only cope with 25% of the casualties today, the rest we will treat next week. When someone has a heart attack you cannot say, sorry we have had too many emergencies this week, we will admit you another time. Although much of this slack is given by staff goodwill, working extra hours without reward, their goodwill cannot make other resources available. Yet most hospitals make no provision for staff holidays, sickness or maternity leave, so that when these events take place there is no one to do the work. Routine work is not done, or it is cancelled even though other members of the team are available. The result is a very efficient organisation that has become an ineffective one.

2.3. Management Problems

So the NHS management finds itself, unlike private industry, without the authority to determine and direct all the activities of the organization. It does not have what is known as primacy. Management in the NHS is part

of a coalition, managers and professionals which is entirely separate from the other coalition of the professionals, doctors, nurses and paramedical professions, of which the medical profession for historical and also logistical reasons of its relationship with the patient, is the most dominant.

Klein (1989) considers that a striking feature of policy making in the NHS is the domination of the medical profession . He states that out of the NHS total labour force of about 750,000, only some 45,000 are doctors, yet he states that a review of the literature about policy making in the NHS is exclusively preoccupied with the medical profession. As Crossman (1972) said the NHS is a "consultant dominated service".

2.4. The First Reorganization. [1972] 1974.

The participation of hospital doctors in management and their contribution to the efficiency of the hospital service was a major theme of the first reorganization and stemmed from doctors being able to direct the use of costly resources with varying, but often considerable, degrees of autonomy. After discussion between the Minister of Health and the profession in 1965, the Joint Working Party on the Organisation of Medical Work in Hospitals was set up to discuss the progress of the NHS, and particularly to review the hospital service. It

produced three reports, (MoH, 1967. DHSS 1972b and DHSS 1974), known as the Cogwheel reports because of the design printed on the covers. The first report recommended the creation of divisions of broadly linked specialities to include consultants and junior medical staff which would constantly appraise their services and methods of provision. Such divisions were likely to be set up on a faculty or speciality basis, such as surgery, medicine, obstetrics, pathology, etc. Representatives of each division were to come together in each hospital as a Medical Executive Committee which would co-ordinate the work and views of the division and provide a link with nursing and administration. The sort of problems they might consider included bed management and the organisation of outpatient and inpatient resources. In fact they became a means of disseminating routine information, and a discussion forum for problems, in addition to being an outlet for airing frustrations.

Most hospital groups gradually implemented this scheme, and by 1972 the second report was able to identify the essential elements of an effective Cogwheel system and to report that particularly in large acute hospitals, the system had been helpful in creating improved communications, reductions of inpatient waiting lists and the progressive control of medical expenditure.

The third report clarified the role of Cogwheel systems in the newly reorganised NHS, because an emphasis of the 1974 reorganisation was the part played by multi-disciplinary teams in integrated management, whereas Cogwheel had been set up as a doctor dominated hospital based arrangement. The third report suggested that Cogwheel should continue to deal with issues where the agreement and action of hospital doctors was the main need, while problems requiring strong collaboration between all professional groups, both within the hospitals and in community services, should be the province of the district management teams and their health care planning teams. It would still be appropriate for Cogwheel systems to concentrate on efficiency issues, and it would be helpful for hospital doctors to see their clinical freedom in the context of team work and the necessity of sharing resources.

Cogwheel divisions have not flourished everywhere, however, but where they have, (Levitt and Wall, 1984) many have required a considerable amount of administrative support. Support for the Cogwheel concept is nevertheless fairly general, and an alternative is difficult to find given the clinical autonomy which consultants have enjoyed. The Royal Commission noted an impatience amongst medical staff with the seemingly inevitable delays intrinsic within consensus management and they supported an executive team at hospital level

which they thought would speed things up. The idea of unit management teams was endorsed in "Patients First" (DHSS, 1979) and in a DHSS (1980) circular on the new structure, but the involvement of doctors was somewhat ambiguously stated. Many doctors feared that the reorganization would be taken as the opportunity to deprive them of their clinical autonomy. Clinical freedom was however built into the reorganized service.

The intrusion of politics exacerbated discontent. A Green Paper and Consultative document in 1972 (DHSS, 1972) appeared to have had as its purpose a closer integration of preventative with curative medicine. As implemented in April 1974 the only overt effect was to make administrative machinery more cumbersome and to separate lay administration more widely from the working doctor. A hospital consultant now had to penetrate several strata of committees before arriving at the source of management. The nature of these new committees intensified the political aspect.

2.5. The Second Reorganization. [1980] 1982.

Following the 1982 reorganisation, unit management teams (UMT) were set up as a quartet of doctor, nurse, administrator and treasurer; in some cases they included a Consultant and General Practitioner. The planned role of these teams is not altogether easy to determine, nor

is their corporate relationship to the District Management Team (DMT), although clear directions were given (DHSS, 1982) on how doctors were to be appointed to the DMT following the 1982 reorganisation. The consultant was to be elected by the consultant body and the General Practitioner by all General Practitioners in a District to serve for a limited period. This marked a change in some places where previously the District Medical Committee (DMC), itself a representative body, had elected the DMT medical representatives.

2.6.0. The Third Reorganization. [1983] 1984.

The Griffiths Report (1983) proposals recommended modification to this type of team decision making. Ironically, it was hospital doctors' criticisms of consensus management which probably did most to encourage the Secretary of State to ask for the Griffiths report in the first place. The resulting proposals that there should be a general manager at District and Unit level led the BMA to state that such a post should be held by a doctor, even though many doctors were doubtful that filling the role would be practicable given their comparative or total lack of management training and their prime commitment to patient treatment which would allow little time for the managerial role.

2.6.1. Some Problems with Doctors

The dilemma cannot be easily resolved. Doctors need to be involved closely with the decisions about health care, but do not wish to spend too much time away from their patients and other commitments like teaching and research etc. It was hoped that the Griffiths proposals would be an effective improvement on Cogwheel and on consensus management, however things changed again with the reforms introduced in 1991.

To a certain extent the idea of a top doctor had been tried before with the Medical Superintendent in some hospitals, and with the Medical Officer of Health in local health authorities before the 1974 reorganisation. Medical Superintendents' posts atrophied well before 1974, but the Medical Officer of Health was sometimes a highly influential officer in local authorities whose work was often widely appreciated, although not usually by hospital consultants. The holders of these posts did not find it easy to adapt to the different management principles following the reorganisation and this has left community medicine in a somewhat ambiguous position.

Possibly this is one of the reasons why there were relatively few community physicians in the early 80's. No one appeared to know whether community medicine was about the management of medical work or about the

management of the community's health. Unfortunately training in community medicine was not the same thing as training in management. Regional Medical Officers and District Medical Officers were not trained for management and their background was not the best qualification for persons expected to give leadership to consultants.

Prestige in medicine has always been associated with possession of skills in the application of advanced technology. Consultants discount the views of Regional Medical Officers and District Medical Officers and Community doctors because they have no direct experience of the problems of being a consultant. This may of course be a phenomenon not unique to medicine. But the consequence is that Regional Medical Officers and District Medical Officers have little authority over consultants. Medical leadership might be strengthened by recruitment of leaders from the more powerful medical posts, and those with formal training in management, and this is an issue which I will be addressing later.

Despite the claims of the Hunter Report (1972) which had tried to amalgamate both the managerial and clinical responsibilities, the Royal Commission felt that the Community Physicians' role in planning, health education, epidemiology and environmental control should be encouraged. This implied that the more administrative tasks should be undertaken by administrators.

Doctors generally do not perceive the impact of their individual decisions on beds, facilities and costs (Weisbord, 1976). But factors that destroy administrative cooperation are that doctors have little interest in management problems. Some managers stated that they felt that doctors are closed minded and aloof, and not really interested in the problems facing the administrator Jacobs (1978). Jynton (1975) agrees that physicians have a tendency to establish themselves as role experts in health related matters. Their "domain" includes all parts of the hospital. According to Hanlon and Gladstein (1984), a common perception of departmental heads, many of whom were doctors, was that they were at best mediocre administrators with little sensitivity to the human side of management.

2.6.2. Interpretation of the Griffiths Report

It is now claimed by Griffiths (1991 and 1992) that both doctors and managers misunderstood the implications of the Griffiths Report (1983):

> " Involve the clinicians more closely in the management process, consistent with clinical freedom for clinical practice. Clinicians must participate fully in decisions about priorities in the use of resources."

In the Audit Commission Annual Lecture in 1991 he said: (Griffiths 1991):

"I personally believed and intended it to be liberating in the sense that doctors and nurss would have the opportunity of having a much greater say in the running of the Health Service."

And again in a speech to the British Association of Medical Managers in 1992, (Griffiths, 1992) he re-emphasizes this:

"From the very outset in 1983 I made it clear that I envisaged a strong role for doctors in the management of the NHS and my report subsequently confirmed that."

However, of greater interest is his statement on general management, in which he says:

"I did not intend that the result should be yet another profession in the National Health Service to work in parallel with other professions".

Not only were the Griffiths recommendations misunderstood, or perhaps reinterpreted later, but also the medical profession, always fearing a loss of clinical freedom, felt unable to grasp the opportunity created, and the reforms were effectively highjacked by management.

Fitzgerald and Sturt (1992) in discussing the Griffith Report (1983) said:

"Despite the strong thrust provided by general management, limited progress was made on the inclusion of clinicians into management decision making."

Harrison (1988) offering an historical analysis up to the late 80s suggested that,

> "some change has taken place but that this has more to do with the *form* of relationships [between doctors and managers] than with the substance."

Enthoven (1985), while sympathetic to the thrust of the Griffith Report, said that in different circumstances its recommendations might make a difference, but only if the structure and incentives in the NHS were changed more fundamentally.

2.7. The Fourth Reorganization. [1989] 1991.

The National Health Service has now undergone the most radical of the many reorganizations in its history. There was intense discussion about ideas for reform which fell largely into two broad views: Either on the theme of replacing the tax financed scheme with an insurance based scheme, or improving the use of existing resources by organizational change. The influence of American ideas on the first, being insurance based, is very obvious but the second theme less so, but attributed to the influence of Enthoven (1985) who advocated an "internal market" within the NHS. As Klein pointed out (1989):

> "There appeared to be a terminal irony in the fact that, after 40 years which had brought a regular procession of Americans to Britain to find out the

secrets of the NHS's success, the process was being reversed: the anorexic were seeking a cure from experts on obesity".

Ministers failed to convince the majority of health care professionals that the reforms would have the desired effect. Nor indeed were doctors consulted, a point of interest as it was the first time that government had failed to consult the medical profession, a theme to be developed in a later chapter on the influence and clinical autonomy of the medical profession. The service continued to work because of inherited good will and almost any system can be made to function if all the members are willing to work within the organization.

There was also the danger that strategic planning would produce plans that did not actually happen. Implementation failure might occur because planning was separated from those that have to work the changes, or because of hopeless optimism, or because implementation problems are denied so that at best only compliance is achieved instead of commitment. At worst this could result in conflict.

The consultants had accepted long term contracts with the NHS and limits on total expenditure in exchange for job security and "clinical freedom". The NHS management has very little leverage to make their services responsive to patient needs. To change the speciality mix of its

medical staff, a Region District or hospital had to wait for deaths and retirements.

Improvements that do occur are often the result of accident rather than design, or because powerful of individuals rather than effective management structure. This is because major organisational change in the health service is often based on assumption and belief rather than substantiated theory or observational evidence. One of those assumptions is that commercial organizational models are directly transferable to public service enterprises.

So we came to the position that in 1989 in the face of a radical reorganisation the doctors were the ardent defenders of a nationalised structure. They had found refuge in the doctrine of central control, regional appointments for consultants and uniform terms and conditions of service to avoid interference from local authorities. Not only had the societies gone but now also the spectre of municipal control. Clinical freedom had been enlarged, and the doctor no longer had to worry about the patient's ability to pay before deciding on treatment. The profession was enjoying greater freedom than at any time since club practice began in the 1820's. It is partly the apparently increasing loss of this freedom, often called clinical freedom or clinical

autonomy, which is an important factor in considering the main question of this thesis.

Until 1948 every doctor had been trained in a medical school which was attached to a voluntary hospital. The student was reared in a spirit of the voluntary hospital. Voluntary hospitals ran on a shoe string. The hospital could only exist if everyone was prepared to help. Everything non essential to the patient's welfare had to be cut to a minimum. Care without direct payment carries on a tradition from the voluntary hospitals that pre dated the NHS. Doctors gave their time free of charge in those hospitals, hence the name. This charitable background may still be affecting many consultants' attitudes, as an influential consultant aged 55, training young doctors today, would have been trained by consultants who entered medicine and had their attitudes shaped in the 1920's.

The voluntary hospital spirit was not one to be forgotten quickly. One cannot identify a date at which good will started to run out, but the process was gradual. New doctors qualified who had no experience of the voluntary hospitals, and what was more important, they were being trained by doctors who also did not have that background. The doctor found himself increasingly frustrated. The general practitioners were debarred from the hospital. The hospital consultant became swamped with a type of

illness that could have been dealt with by a general practitioner. Specialized medicine and surgery became more complex and time consuming, but had to be fitted into the routine work. A highly trained and skilled specialist surgeon found himself repairing hernias and removing ingrowing toenails. It was very useful and necessary but could have been done more economically by less skilled staff in Primary Health Centres, had they existed, an idea first suggested in a report (Dawson, 1920) on proposed reorganization of health care in Britain in 1920. This emphasised bringing together of preventative and curative medicine. Specialist advice would be available at a Primary Health Centre, but the main working area of the consultants would be in the Secondary Health Centres, located in a hospital capable of undertaking diagnosis, care and treatment of the more difficult case. This idea was to surface again more than once, particularly with the birth of the NHS. Cartwright (1977:166) describes this Dawson report:

> "This revolutionary plan is one of the more important, although tragic, documents in the history of British medicine."

What had gone wrong? Some would blame the senior doctors holding that they are too conservative, and unwilling to move with the times (Klein, 1983). Yet it is the younger ones who are actively expressing disillusionment. Some point to increasing interference by party politicians.

Perhaps we are passing through a transition phase from one form of medicine to another, and such periods of transition are historically accompanied by convulsions. Curative medicine, although based upon science, is afterall still primarily an individual art, and creative artists do not take kindly to bureaucratic control.

2.8. In the United States.

In the States medicine is also changing, with many external forces reshaping medicine in ways that the profession did not like. It was put succinctly by Bailey (1990) when he described the differing beliefs of the four major groups:

> "Doctors believe that health care is worth what it costs, that it will continue to improve and that it will continue to cost more. They believe that patients government and corporations need to understand the primacy of quality and need to bite the bullet in terms of cost.
>
> Patients believe that health care is no longer a privilege, that it is a right. They also believe that there must be a way for them to obtain high quality low cost readily accessible health care.
>
> Business believes that the process of utilization review is being "gamed" and that the health care system is inefficient because physicians are poor managers. They also believe that money can be shifted within their corporate structure from health care costs to corporate profits if they can rearrange the manner in which health care is provide.
>
> Government who believe that health care is an extremely important issue as health care policy can win or lose votes for individual politicians. Government in the US also believes that it can decrease its share of the cost of health care."

Bailey continues by explaining that based on these beliefs each group has drawn a set of conclusions that are taking shape in the decisions that are now being made and are reflected in the impact these decisions are having.

Doctors have concluded that patients want quality care at bargain rates but that only a few of these patients are serious about preventive medicine. Doctors have also concluded that the government is playing politics with the nation's health care system and that business and corporate interests are lobbying effectively to lower doctors' fees (and hence their income) through direct employment by health maintenance organizations, fee discounting and moves in the general direction of a national health care system.

Patients have concluded that doctors charge too much, make them wait too long and do not really care about them as individuals. They have concluded that the government can design a system that will give them low cost, easy access and high quality medical care when they are old and/or out of work. Friedman (1991) writes that the public has also concluded that business has an obligation to provide total health care benefits:

> "the unspoken agreement was that, if a person was employed, he or she would receive health insurance benefits".

Such insurance, according to Bailey (1990) costs in excess of $2,000 per person per annum but, employees wish to pay no more than $200 per person per year for it.

Next he states that business has concluded that doctors are responsible for the increases that have occurred in health care costs and as a result doctors are pushing industry into a zone of non-competitiveness. Corporate America has also concluded that patients will over use any health care plan that can be provided and therefore that the government can and should solve the financial problems of business through the implementation of new forms of health care similar to the Canadian system, which offers universal coverage through public sector insurance administered by officials at the provincial level who are the single payer and negotiator of budgets for hospitals and fees for doctors (Holahan, Moon, Welch and Zuckerman 1991).

Lastly Bailey says that government appears to believe that doctors provide too much unnecessary care and are responsible for increased use of expensive services. Government has also concluded that patients are willing to accept a system such as the Canadian system or the Veterans Administration Hospital system and that business

can serve a useful purpose as the catalyst for driving the shift to increased regulation and decreased reimbursement for health care.

2.9. Some Present Dilemmas.

So clinical freedom is seen by doctors as again under threat, this time from a government determined to make doctors more accountable for the work they do. It feels that clinical freedom has gone too far, producing a kind of anarchy where the government has lost control of spending. The government believes a balance must now be struck between organization and freedom. Whether reasonable or not the public have to determine. There is a situation of mutual dependency. (Klein, 1990);

> "the state became a monopoly employer: effectively members of the medical profession became dependent on it.....the state became dependent on the medical profession to run the NHS and to cope with the problems of rationing scarce resources in patient care."

The health care industry is said to be under pressure in both countries to reduce costs and increase efficiency without sacrificing the quality of patient care. However all those within the health care industry appear to feel that changes are strictly a cost reduction exercise with little consideration for the quality of patient care. No one however has yet focussed on the relationship between the two most powerful influences in hospital health care

delivery, the manager and the doctor most involved in daily management often called the Clinical Director. If the relationship between the most powerful actors in healthcare delivery becomes more cooperative and less adversarial, creative energy can assist both administrators and physicians. (Simendinger and Pasmore 1984).

More than in any other institution, the hospital provides a unique arena for studying factors affecting cooperation among those in positions of power. Unlike industrial organizations the dual hierarchy of hospitals sets up barriers to, and at the same time necessities, for co-operation between doctors and their managerial colleagues. Over the decades there has been a gradual change from a doctor managed health care system to a joint doctor/manager team. The management of a hospital has become a joint venture. Some would argue that the pendulum has swung even further, to a primarily professionally managed hospital health care system. The challenge now is for the medical profession, in the words of Klein (1990),

> "to run the NHS and to cope with the problems of rationing scarce resources in patient care".

Klein continues:

> "Given the certainty that conflict will continue and the possibility that the NHS may be living off an inherited but not necessarily renewable capital of

commitment and loyalty is it possible to devise better strategies for managing the resentment generated by mutual dependency of the state and the profession?"

2.10. Lessons from Industry for the Health Service

Griffiths (1983) emphasised the similarities as;

a. The need to identify and satisfy real needs.
b. Delivery of the highest quality of service.
c. Securing a trained motivated workforce.
d. Setting short and long term objectives.

More important however are the differences. Smith (1984) says differences do exist and highlights them as;

a. prime motive is service, not profit.
b. beneficiaries are the public rather than owners.
c. performance measures are more qualitative.

He brought together a group of NHS and commercial managers and asked them to identify those dimensions of organizational life which differentiate the NHS from private sector organizations. They found this relatively easy and identified nearly fifty such parameters. They felt the following were the most important:

COMMERCIAL ORGANIZATION	NHS
Coherent / Single Power Source	Diffused / Multiple Power Source
Single Profession	Multi-professional
Few external pressures	Extensive external pressure including public image
Clear objectives	Diffuse objectives
Clear customer	"Confused patients"

They represent what Maslow (1972), the late psychologist, called low synergy institutions. The reason why they are different is because hospitals are in fact professional bureaucracies and these differ in a number of ways, most notably because professionals have some control over task performance, task review and planning.

Hospitals have few of the formal characteristics of industrial firms (Friedlander, 1976); physicians and scientists are socialised to form a rational, autonomous, specialized, expert behaviour, which is antithetical to

the organization of any but the most narrow individualized pursuits (Friedson, 1970b:xi);

> "Health services are organized around professional authority, and their basic structure is constituted by the dominance of a single profession over a variety of other, subordinate occupations."

Early studies of hospitals by sociologists were made with studies of the factory in mind, and in general their view was that improved communication within and across the organization would settle difficulties of operation. But one problem at least, that of reconciling expert with hierarchical authority, remained. And the degree of expertise is very important in this problem. As Friedson (1970b:24) puts it:

> "skill of such complexity and refinement that autonomy of judgement is necessary."

Smith (1958) emphasised two lines of authority, administrative and medical, and drew attention to the difficulty of operating with such a system. Goss (1961) studied how autonomy of professional judgement could exist in a hierarchical and supervisory hospital setting and observed

> "that the two lines of authority are both established and maintained by the segregation of administrative decisions from areas where professional judgement was considered necessary, the former freely made and enforced by the authority of office, the latter left to the "authority" of the individual professional."

On this foundation Goss constructed an organization model called "advisory bureaucracy". Friedson (1970b:90) refers to it as "professional bureaucracy". According to Engel (1969) and Scott (1965),

> "The essential characteristic is that professional work is free from the exercise of the authority of nonprofessionals even though the working professionals are technically subordinates in a bureaucratic system".

However Bucher and Stelling (1969) feel that the concept of bureaucracy may be entirely inappropriate for professional settings.

According to Weisbord (1976), hospitals require three different social systems and not one as in industry. The links among the task system which administrators manage, the identity system which underpins professional status, and the governance system which sets standards, are extremely tenuous.

Inglehart (1983 and 1984) described the NHS not only as probably the nation's most popular institution but as also the largest and it is probably more complex than any other national enterprise. The average District Health Authority has, (or had before some split into trusts), many more employees than the average company. With unintegrated management, professional hierarchies and many external pressures, confusion of goals, internal competition for resources, differing disciplines all

having differing internal goals, no organisational priorities, clinical freedom, contradictory perceptions of management, lack of reward system, and the need for organisational slack, it is not one of the easier organizations to manage.

CHAPTER 3

DOCTORS AND HOSPITALS

3.0. Introduction

The first half of this chapter sets the background to the way in which some doctors have become involved in hospitals. The second half from section 3.5. illustrates the manner in which doctors are now involved in allocating the resources of a hospital.

3.1. Historical Background

Historically the earliest hospitals were not founded for the primary purpose of medical care as we know it today. Many of those admitted were physically ill so nursing care was often necessary, and as a result medical opinion was sometimes sought, although medicine of the time rarely had much to offer. They were usually suffering from chronic or terminal illnesses and the hospital was only able to make them as comfortable as possible. Most medical practice in those days was conducted in the home.

In the early days, control of nursing staff in the hospital was entrusted to a "lady", educated, usually wealthy and of some social standing. Cartwright (1977).

"All too often these condescended to their work, regarded themselves as 'gifted' to clear up the mess made by the ignorant male, and treated their colleagues, administrators and medical staff alike, as underlings whose sole duty lay in obeying their commands. Miss Nightingale experienced endless trouble of this kind."

3.2. Doctors' Involvement in Running Hospitals

There are all sorts of ways people can run complex organizations and it is important to define the use of the term "running" a hospital, an issue already addressed in the first section in Chapter 1. Most of the cost of running a hospital is the result of doctors' orders, so in that sense they do run a hospital, but they do not run it in an executive sense. Chairmen of departments or Clinical Directors can have varying degrees of influence in planning and resource allocation, and this influence depends very much on the degree of devolvement of central power and authority within that institution.

Generally, although doctors' influence in running hospitals had been diminishing in a strategic sense, it has not changed in a daily operational sense. Hence the relationship between doctor and administrator or manager has developed to a complex relationship regarding the doctors involvement in the organizational problems of today.

It was not until later in the nineteenth century that the doctor began to play an important role in the hospital. Even after those times the doctor was not involved and indeed had no need to be involved in the management of the hospital (White, 1991);

> "In early times the doctor was very much in control of his patients his authority was unquestioned in the care of the hospital patient. Professional independence was reinforced because for years the centre of his practice had been the home. Hospitals gradually developed but he continued to guard his position even when the patient was in hospital. In the second half of the twentieth century the hospital and medical treatment have become more complex. There are large numbers of people involved in treatment. As the organization has grown in size there has been a move away from professional independence to interdependence".

In some hospitals in the United States doctors did try running hospitals but they failed for a number of reasons to be discussed in the data Section 4.

Hospitals up until fairly recently were cottage industries and the craftsmen or the technicians were the doctors who ran their "workshops" within them and maintained complete and total authority over their own areas.

3.3. Management of Hospitals

Hospitals were of course not founded by the medical profession or operated by them when they were founded and perhaps it would be interesting to speculate whether, had

this been the case, they would be very different institutions from the ones they are today. The doctors were not originally a part of the organization, although they had a vital role to play in the organization and this does explain why the doctor, with certain exceptions such as privately owned hospitals and nursing homes, was never in control of the institution. It is as the result of this historical development that many of today's difficulties facing the relationship between doctors and managers have arisen.

Drucker (1977) states that,

> "hospitals everywhere present the same confusion of missions and objectives with resulting impairment of effectiveness and performance".

Should a hospital be in effect a doctor's work facility as many older doctors believe?

Should it focus on the major health needs of a community or should it try to keep abreast of every medical advance no matter how costly and how rarely used that facility will be?

Should it focus on preventative medicine and health education for the community, or should it concentrate on the repair of health damage already done?

These are only a few of the possible definitions and objectives of a hospital, and as every one can be defended, every one deserves a hearing. The effective hospital will be a multi purpose institution and try to strike a balance between various objectives. What many if not most hospitals do however is to pretend that there are no basic questions to be decided. According to Drucker (1977) the result predictably is confusion and impairment of the capacity of the hospital to serve any function and carry out any mission. One hospital in my study states its purpose as;

> "to provide acute care that utilises the most advanced diagnostic and therapeutic techniques available, to be a centre of medical excellence,"

but it then continues paradoxically by saying:

> "and meets an agreed standard of quality within available resources."

Another mission statement began:

> "We aim to be the finest District General Hospital,"

but then went on to say:

> "We also aim to be a specialist centre of excellence."

Also being dependent on a budget allocation at whatever level placed, i.e. District level before the reforms of April 1991 or Purchaser level post April 1991, militates against setting priorities and concentrating efforts. Nothing worthwhile is usually accomplished unless scarce resources are concentrated on a small number of priorities. Being budget based appears to make it more difficult to abandon the bad things, the old and the obsolete practices. As a result Drucker (1977) feels that hospitals like all service institutions are more encrusted than businesses with the barnacles of inherently unproductive efforts.

3.4. Life and Work in Hospitals.

Although hospitals are often thought to have a unique administrative structure they do have some similarities to a number of Human Service Organizations, and inherent complexities (West, 1988):

> "The large number of separate decision makers in the professions is what separates health care from most industrial and service industries."

Nelson (1989) however takes a different view;

> "In many ways, health services are not different from any other service industry or, indeed, any manufacturing industry."

Drucker (1990) regards hospitals as one of a number of "non-profit organizations" which do different things from business, which supplies goods or services, or government, which controls;

> "A business has discharged its task when the customer buys the product, pays for it, and is satisfied with it. Government has discharged its function when its policies are effective. The "non profit" institution neither supplies goods or services nor controls. Its 'product' is neither a pair of shoes nor an effective regulation. Its product is a *changed human being*. The non-profit institutions are human-change agents."

All appear to agree that improved employee morale can improve organizational effectiveness. Davis and Cherns (1975) and Cummings and Molloy (1977) indicate that it has come to be accepted that an organization should be responsive to the social and psychological needs of its employees, and that improvements in the quality of work life are often linked to improvements in organizational effectiveness.

Despite the government's expectations of hospitals to increase efficiency, consideration of employee morale has not appeared to have been a feature of these demands. The complexity of the hospital, lack of goal clarity and the conflicting interests of different groups are formidable barriers to improving operating effectiveness and the nature of work life within the organization. (Hanlon and Gladstein 1984).

The hospital is not one organization, but a collection of empires in competition with each other for beds, money, manpower and other resources. To many who work in hospitals apparently there is no one higher than the consultants, no higher authority. Until recently the administrators were regarded as "the mere servants of the kings". They co-ordinated, and tried to keep the building and the non-medical staff functioning. They would not and it appeared could not interfere in any way with the way in which the consultants ran their kingdoms. Nor could they, being without medical qualifications, make valid priority judgements between departments. The old District Management Teams often decided who should get large sums of money under much pressure from the lobbying of a powerful consultant or group of consultants. But the consultant in his own department was autonomous. Only he decided how many patients to operate on, what types of operations to perform and how many patients were seen in his out-patient clinics. But significantly his power extended even over non clinical matters. As one consultant told me,

> "He could even have a door moved a few inches to suit him"

Following the various reorganizations new types of administrators and managers took over, but they were still largely without power, respect, or seniority. They

were regarded only as housekeepers, and they had a hard time trying to control the hospital (Toynbee, 1979);

> "The Administration had sent out directives to all consultants to admit only emergency cases. The laundry had ceased to function effectively and there was a severe linen shortage. The orthopaedic department suffered particularly since many of their admissions couldn't easily be categorized as emergencies. There was a lot of wheeling and dealing going between the consultants. I was with Dr Goodwin of the nephrology department one day during the dispute. He was pacing the wards, whispering to the Sisters. In one of his wards he found that a prudent Sister had stockpiled a vast amount of linen, plenty to keep his non-emergency admissions flowing. The sister was anxious that he shouldn't tell the Administration that she had all this extra linen, as she wanted to keep it for her ward. "Do you think we could? Could we just admit a few, do you think?" he asked her conspiratorially. He went down to the Administrators in the end, and being careful not to disclose the ward in question said, "If I found the linen could I keep admitting my patients? There was a fairly indignant "no" from Administration, who were hard put to find enough linen for their emergencies. Dr Goodwin huffed off, in a bad temper, and no doubt the Administrators ordered a quick search of some of the ward linen stocks".

This anecdote shows how consultants operate in complete isolation from the rest of the hospital. They are almost completely autonomous. The consultants fight out amongst themselves in a series of complicated and unsatisfactory committees. Each of them strives to increase the size of their domain. Few, it seems, have any consideration for the general good of all patients, only, putting it at its best, caring for the rights of their own patients.

There is a belief amongst consultants, unassailable and inviolable, that nothing, no authority in the world must

come between them and their patients. They and only they must have complete freedom to prescribe the right treatment. It is on this basis that the consultants can build around them such powerful empires. There is no one above or below them to challenge their authority. (Toynbee, 1979);

> "I regard the Health Service as nothing more than a mechanism for paying for medical care of the patients, a sort of insurance, and nothing more. We consultants have no loyalties whatever to the Health Service, nor should we. All our loyalties are to our patients and the hospital."

A comparison has been made between doctors and airline pilots. (West, 1988a);

> "It is widely accepted that planes need well trained independent professionals to cope with whatever situation develops. But it is also accepted that the autonomy can be exercised within limits of financial and organizational efficiency set by the airlines. .....Furthermore, customer safety requires detailed reviews every six months to check on the competence of the pilot in a range of situations."

Care without direct payment of course carries on a tradition from the voluntary hospitals that pre dates the National Health Service. Then doctors gave their time free of charge in those hospitals, hence the name. Several people I interviewed thought it probable that this charitable background may still be affecting the attitudes toward patients of many consultants today.

Patients effectively have no purchasing power, they do not control the transaction in a market way. The consultant is paid a salary and the poor performer is paid the same as the best. I am of course ignoring the distinction award system, set up by the Spens Committee (M.o.H, 1948) in 1948 which rewards those consultants whose work is "over and above the call of duty" (Toghill, 1992). The subject of debate and criticism, it is an endemic controversy within the medical profession (Dawe, 1992). Doctors are extremely reluctant to talk about this system of secret payments, but managers are more forthcoming, for instance DGM;

> "The strong grip that a few individuals have over the majority, means that it is often the case that out of say one hundred and fifty consultants, we only have to persuade three to press our case. They can all stand-up and rattle, but if the three Godfathers dissent, the views of the other don't matter. There is something inherently wrong with that arrangement in my view, and I cannot understand it. It will be perpetuated and can only be altered from within the profession itself."

Where the patient has a direct input into the choice of doctor and where an insurance fund will reward doctors for the treatments and service provided, as in the United States and many European countries, there is obviously an incentive to keep the patient happy and informed about the treatment.

Another factor, alluded to earlier, is that a consultant aged about 55, training young doctors today, will have

been trained by consultants who entered medicine and had their attitudes shaped in the 1920's. According to Devlin (1985b);

> "There has been a sort of cosy consensus among the surgical oligarchy since the inception of the NHS or, more correctly, since the then oligarches returned from the 1939-45 war and diecast the NHS in the most favourable view they took of the surgical practice they had known prior to September 1939."

Doctors also came mainly from higher income groups and were chosen for their performance in science examinations and it is not surprising that they are frequently lacking in the area of customer relations. This pattern may however be altering (Lowry, 1992);

> "that attitude is now changing, more schools acknowledging that people with only moderate academic achievement can cope well with the course and often have more to offer in terms of personal skills, attitudes and experience."

3.5. Consultants Use of Resources in Hospital.

The second half of this chapter is devoted to the way in which doctors are involved in the use of resources in hospitals. This is important because it reveals the extent to which they are major users of resources and can therefore have an equally large effect on managing those resources in a way which managers themselves cannot. It also demonstrates some of the lessons which Clinical Directors have had to learn about the ways in which a

hospital operates, and what proportions of resources go into various aspects of the running of a hospital. It also demonstrates some of the areas in which change is occurring, for example in the culture, particularly to such things as bed holding for status and empire building in general.

Consultants use two main types of resources in hospital, those whose use they control more or less directly, and those where a task is referred to a service department. A clinical or bed holding firm is usually allocated a number of inpatient beds or wards with supporting facilities and outpatient clinic time at one or more hospitals. For surgical specialities in addition there will be an allocation of theatre time with anaesthetic services and related equipment. But beds are usually the most important and expensive resource.

3.5.1. Directly Controlled Resources

The resources directly controlled by the firm are used in a way of the consultant choice. For some consultants beds are equated with status and their use will not be surrendered to colleagues even when for clinical or other reasons their occupancy is falling. They keep them full unnecessarily to prevent emergency cases from other firms blocking their next day's elective list admissions, a problem especially common in winter. To be fair about

this however, one might consider how one would feel if on coming into work we found our desk (if we had one!) taken over by others, leaving no room for us to do our own work. Without incentives, the choice of how beds are used might not be efficient for the hospital. A consultant therefore has until recently usually taken no real interest in the management of hospital beds and faced few penalties for this lack of interest.

The use of operating theatres involves similar difficulties as with hospital beds. Theatres like beds are not always used effectively and a good deal of frustration results. One cause is lack of clear management and this could change in the new management structures which I shall outline in later chapters. Since managers have no real control over the consultants they can only make sure that a theatre is ready to provide the service expected of it. They cannot make the service happen. Theatre User Committees exist but for these to function effectively the consultant members may need to challenge each other about the use of facilities, something they rarely consider. Medical etiquette, loyalty to the profession and the "medical mafia" serve to prevent change.

The cost of under usage of theatres, or any other facility, is negligible to the consultant, but expensive for the hospital. Over use causes overspends beyond

budgetary allocations, provokes irritation in theatre staff who may have to work longer hours unpaid, and keeps any surgical colleagues waiting. According to West (1988b);

> "A more fundamental problem is the mismatch between the rate of detection of problems by GPs, confirmation by the consultant at outpatient clinics, and final treatment. A patient may be diagnosed in minutes for a condition that will take hours of direct treatment and days of hospital stay. As a result a waiting list starts to build up for either treatment or outpatient clinics.....There is no real incentive to improve performance."

For surgeons especially there may be an imbalance between outpatient work and theatre time. It may not be easily practical to change this, nor in the consultant's interest for his private practice, nor may it be possible for the manager to change because of resistance from the profession in general. In the past managers have no clear incentive to increase performance, where even if the number of patients treated increases, the income to the hospital does not. With the new internal market, the more efficient a hospital becomes, spare capacity may be revealed which cannot be filled if purchasers have no money for extra work.

A further issue is that a consultant and his firm using resources for one case does not allow this to affect his firm's decision about another case as it would have no

immediate, direct or apparent effect on their total resources. The service is apparently free to them.

3.5.2 Investigations and Resources

There are also at least three ways in which overusage of resources by investigations may occur. The first, which might be called legal over usage, and which tends to be more overt in the States, is the overuse of resources as a result of defensive medicine. This is practiced to avoid potential criticism particularly if there is future litigation or legal action and usually means doing everything possible, in detail, even when the clinical gain may be small or non existent. The second kind is junior professional overusage, where overuse may be practiced by junior hospital doctors to defend themselves against criticism by their consultants on a ward round. And the last is patient overusage, where there may be overusage of diagnostic services authorized by a doctor because of the need to demonstrate concern or to reassure the patient that a problem is receiving attention, is under control or is not a significant problem after all. There is the very significant problem of unreal expectations by patients of what can be done for them, often reinforced by an abrogation of GP responsibilities regarding referral.

Whatever the extent of these forms of defensive medicine, particularly the last which is widespread, because doctors are motivated to help people and may push this to the limit where they think it is worth trying, nevertheless as a result of the lack of incentives that have faced doctors, resources may not be used in ways that health economists and others might regard as efficient.

The trouble is however, that while everyone agrees that waste is a bad thing there is frequently no general agreement on the right clinical regime for a given patient with a given disorder, and audit and protocols are at present in their infancy as well as time consuming. With all this uncertainty it is probably wiser to think of improving hospital efficiency by eliminating obviously wasteful activities rather than trying to aim for medical consistency on patterns of resource use when there is no consensus on the right treatment.

3.5.3. Service Controlled Resources

So far we have only considered the so called bed holding clinical departments, but not the service specialities who have rather different problems with resources. They are the departments such as anaesthetics, pathology and radiology providing a service to other specialities in

the hospital. Faced with a rising demand, they have either to increase their output from the resources available, which means everyone must work harder, which is likely to be unpopular; or they can claim more resource to meet demand at current level of efficiency, such extra resource rarely being available; or they have to restrict demand, which means disputes with clinical departments and difficult decisions about priority and rationing.

It has been easier to pursue efficiency in the non clinical support services such as cleaning, catering and the other hotel services, where there is no direct question of a threat to healthcare from reductions in staffing, although reducing or at least controlling demand is increasingly seen as an alternative way to cut expenditure within hospitals.

3.6. The Traditional Control of Resources

In many hospitals it appeared that the district administrator was already behaving as a Chief Executive, and administrators and managers with a strong personality effectively steered the unit. In other hospitals a different member of the team was the real leader and in some hospitals, doctors became involved in management and this is the subject of much of the discussion in later chapters. Traditionally in the National Health Service,

doctors had taken or been given little or no responsibility for budgets. Neither had they been given or taken much interest in the resource implications and the costs of their decisions.

The early National Health Service hospitals had run very much like the model of a private hospital, or to some extent how American hospitals were run. In other words the doctor was not really regarded as an employee of that institution and until 1991, consultants, except those in teaching hospitals, were generally employees of the Regional Health Authority. They advised the managers of the hospital about what needed to be achieved medically, and it was the task of the managers to do their level best to satisfy the needs of the doctors. For the doctor it was a comfortable system.

To some extent from 1948 until the late 1970's it ran in that sort of way and each year more and more money was spent. Perhaps there were not as many increases as were happening elsewhere in Europe, or as much as doctors would have liked, but nonetheless each year, more was spent. The years of 1948 to 1978 were, relatively speaking, the years of plenty .

Then came the years of famine, with cash limits in 1979 and cash planning in the early 1980's so that the old ways of running hospitals no longer applied. There is

nothing unique about the National Health Service. Every country in the world is facing exactly the same problem of not having enough resources to achieve everything they would like to achieve, and therefore choices have to be made.

So the question raised was how to involve doctors in management and there are a number of ways in which doctors can be involved in and feel to be part of management in acute hospitals. The Griffiths Report (DHSS, 1983) emphasised the need for doctors to assume managerial responsibility, and suggested this may take place in two main ways:

a. By involving doctors in management within hospitals.

That was to say, by involving them in the management of resources which endeavours to make them more cost conscious.

b. By appointing doctors to general managerial posts.

3.7.0. Doctors'Involvement in the Management of Resources

Experience from other countries shows that doctors have not regretted participating in clinical budgeting. One of the main advantages is the strengthening of the doctors' position when negotiating resources. It enables discussion on standards and quality of care to be part of

that discussion and some consultants have found this to be an incentive. However, some managers paradoxically feel that giving doctors resource management type information could be manipulated by consultants and intensify their "shroud waving" ability and not necessarily make them better team members. Also consultants are generally unhappy with management interference in medical workloads and they frequently distrust the accuracy of information.

There have been a series of attempts to move away from functional budgeting and to involve doctors more, each attempt increasing the degree to which they have been given more involvement, and these may be summarised as follows.

3.7.1. Clinical Budgeting

There is therefore a gap between the clinicians who make decisions about which patients to treat and how, which has had a major impact on resources use, and the managers who have the responsibility for controlling a budget and keeping within cash limits. Managers did not see it as their role to be involved in negotiating with clinicians how resources should be used. Nor since the beginning of the National Health Service have doctors wished to fill this role. Clinical Budgeting suggested that plans should be agreed by clinicians in conjunction with

service providers and finance officers. Those plans should incorporate objectives for clinical activity, specifying the details of resources required into a financial statement. The essential change with Clinical Budgeting was the securing of an agreement with clinicians on a budget.

3.7.2. Management Budgeting

The Griffiths Report (DHSS, 1983) emphasised the need to involve doctors more effectively in the management of resources. It pointed out what has been emphasised on many occasions that it is the decisions of the doctors that largely determine how resources are used.

Griffith argued that clinicians should accept the managerial responsibility that went with the clinical freedom. He recommended (DHSS, 1983) that health authorities should

> "Involve the clinicians more closely in the management process, consistent with clinical freedom.
>
> Clinicians must participate fully in decisions about priorities in the use of resources.

Clinicians need administrative support, together with strictly relevant management information, and a fully developed management budget approach."

Clinicians, although previously involved informally and implicitly with Management Budgeting, were in future to be involved formally and explicitly in financial management and decision making, and to be responsible for those decisions. The proposals thus had profound effects on general managers, treasurers and other professional groups, especially nurses. The discipline of management budgeting also meant that doctors would be accountable for their actions to a manager who might not necessarily be a doctor, a move which would have little appeal to the profession. It was essentially, however, similar to Clinical Budgeting.

A review of Management Budgeting (DHSS, 1986) concluded that it had failed to achieve its objectives due in part to a failure to win the support and commitment from key personnel, the absence of clear management structures and the rapid speed with which it had been introduced.

Management Budgeting was not just a matter of agreement between doctors and managers but required doctors to take responsibility for the budget, although accountability remained somewhat vague.

3.7.3. Resource Management

A new initiative was therefore needed and in 1986 it came in the form of Resource Management (DHSS, 1986). The new approach was to aim for greater medical and nursing involvement, with a focus on measurable improvements in health care through better use of resources. There was a recognition that nurses and clinicians needed to be more involved than hitherto. The architect of the scheme, Mills (1987) states:

> "The resource management programme is principally about changing attitudes and encouraging closer team work in managing resources among patient care professionals and between such professionals and other managers".

Resource Management was intended to provide accurate and useful information to clinicians about their practice and costs compared with colleagues in the same hospital, district or region. In a sense it was the forerunner of medical audit in that it sought to encourage doctors to review performance and improve standards of health care. While some consultants found this information interesting and even useful, some became anxious about comparisons.

Winning over clinicians to Resource Management was going to take time. Earlier initiatives had failed because they failed to convince clinicians that they had anything to offer. Indeed the DHSS used the words "seriously antagonised" (DHSS, 1986) and went on to say that "there

may be a case for suspending Management Budgeting development for the time being"; Devlin (1985a) said that

> "unrewarding for the clinician, a fact that management consultants agreed in private conversations. In a cutback situation the health authority is having to grab every penny it can and will only squeeze further, consultants who improve their output. I think management budgets by incentive is fraudulent unless the clinician is prepared to go home and rest when he has reached his target output - doing more, more efficiently, negates the savings the health authority is really out to achieve. savings, not efficiency, is the real bottom line."

Resource Management therefore emphasised the human relations, whereas Management Budgeting was finance led; Resource Management was more concerned with making doctors more management conscious and accountable for the resources used. By now the doctor and manager had agreed the budget, and the doctor had been given responsibility and made accountable.

3.7.4. Clinical Directorates.

Here Clinical Directors or Clinical Chairmen (the terms vary between hospitals) are responsible and accountable for consultants and other medical staff within a directorate, and have the authority to manage the directorate. In a classical case the Clinical Director is supported by a Business Manager and Nurse Manager and this is described more fully later. One of the problems in the Health Service is that we tend to use the same

word for a number of things; many hospitals now have Clinical Directors and yet what they actually do regarding responsibility, authority and accountability, varies from hospital to hospital.

Here finally the doctor was given authority in addition to accountability and responsibility. These are issues which will be discussed in depth in later chapters as it is in this way that the current changes are occurring in many hospitals. And they are the changes which seem to be producing most effect.

It is probably useful to summarise the changes in tabular form:

DATE	BUDGETING	DETAILS	CONTROL BY
	Functional	Nursing Medical Staff Estates etc	Managers
	Clinical	Agreeing finances	
1983	Management	More medical involvement	
1986	Resource Management	Doctors supplied with information on costs, both absolute and comparative.	
1989	Clinical Directorates	Everything in directorate.	Doctors

More important regarding these are the differences within in the various stages of development, with regard to agreement, responsibility, accountability and authority which may be summarised as follows:

	Aggreem't	Respon'ty	Acc'blty	Auth'ty
Functional Budgeting				
Clinical Budgeting	Yes			
Management Budgeting	Yes	Yes	?	
Resource Management	Yes	Yes	Yes	
Clinical Directorates	Yes	Yes	Yes	Yes

3.8. Appointment of Doctors to Managerial Positions.

Few doctors were willing to take general managerial posts. A small number were appointed in 1987 less than 8% at Regional and District level and less than 19% at Unit level (Stewart and Dobson, 1988). They were often on a

part time basis, and the number has since fallen. A number of reasons have been given for this including (Scrivens, 1988):

Limited interest in management roles.

Lack of training in management skills.

Lack of ability in management skills.

Lack of suitable financial rewards for doing so, as it would have meant a cut in salary.

A feeling from colleagues that in doing so one had crossed to the other side if one were full time, and being part time was difficult.

There were difficulties in maintaining a career by abandoning all or even part of your clinical work.

CHAPTER 4

THE MEDICAL PROFESSION

4.0. Introduction

This chapter shows how the separation of general practitioners and consultants arose, an important factor in the development of doctors and hospitals, and also helps explain the background to some of the present day problems.

4.1.0. Historical Background

The practice of medicine has from time immemorial been shared by orthodox and unorthodox attendants. Until very recently the larger part of the population depended upon unorthodox, unqualified practitioners. An unorthodox practitioner is not necessarily a charlatan. The bone setter, for instance, had an intimate knowledge of skeletal anatomy and based his practice on that knowledge. He became a charlatan only when he strayed outside his "speciality" (Cartwright, 1977).

The first Medical Act introduced by Henry VIII in 1511-12 made it an offence to practice physic or surgery unless the practitioner was a graduate of a university or had been licensed by a bishop of his diocese after

examination by a panel of experts. In 1518 Thomas Linacre, an Oxford graduate and MD of Padua who had served as tutor and physician to Prince Arthur, elder son of Henry VII, and continued to act as a physician to Henry VIII, petitioned Henry and obtained a charter establishing a Company of Physicians which became the Royal College of Physicians in 1551.

4.1.1. Physicians, Surgeons and Apothecaries

It is important to realize, and this has implications today, that before the eighteenth century the medical profession was divided into three groups, the physicians, the surgeons and the apothecaries. The physicians had the highest status; they were graduates, usually of Oxford or Cambridge, who had received religious and classical educations and subsequently had studied medical subjects in European Universities. The surgeons were craftsmen organised in a Guild associated with the barbers and they were licensed to perform a range of procedures that could be carried out on patients without anaesthesia (Drucker, 1968):

> "Until well into the seventeenth century, surgery was performed not by doctors but by barbers who, untaught and unlettered, applied whatever tortures they had picked up during their apprenticeship. Doctors, observing a literal interpretation of their oath not to inflict bodily harm, were too 'ethical' to cut and were not even supposed to watch. But the operation, if performed according to the rules, was presided over by a learned doctor who sat on a dias well above the struggle and read what the barber was supposed to be

doing aloud from a Latin classic (which the barber, of course, did not understand). Needless to say, it was always the barber's fault if the patient died, and always the doctor's achievement if he survived. And the doctor got the bigger fee in either event."

In 1540 Thomas Vicary who had become a surgeon to Henry VIII five years previously, secured the King's assent to a union of all the scattered Guilds in England to form the United Company of Barber Surgeons. Separation of the two took 200 years to complete but the surgeon was no longer required to act as a barber and barbers were restricted to dentistry.

Apothecaries were tradesmen who from 1617 were licensed by the Society of Apothecaries to sell drugs prescribed by physicians, as well as groceries. Historians think that James I initiated the separation, for in 1606 they separated from the grocers and in 1617 were granted a charter of the Society of Apothecaries. The grocers tried to reabsorb them but were frustrated by the personal intervention of James I.

4.1.2. Development of Hospitals

Before the eighteenth century treatment was essentially carried out in the home of the patient. Between 1700 and 1850, partly because of the rise of the great voluntary hospitals, hospitals became more important in patient treatment particularly as they provided a setting for

developments in surgery. In the reign of Queen Victoria (1837-1901), nearly every year saw a new voluntary hospital being founded (Kirby, 1991). By comparison the physicians hardly advanced their techniques and abilities. The prestige of surgeons rose and in 1745 the Company of Surgeons was founded, completing the independence from the barbers and enabling educational standards to improve. By 1800 the Company had become the Royal College of Surgeons of England.

4.1.3. General Practitioners

Apothecaries also advanced and by 1703 they were entitled to see patients and prescribe medicines themselves. This resulted in the appointment of general practitioners for the middle classes and the poor. The Apothecaries Act of 1815 gave the Society of Apothecaries the right to license those who had served a five year apprenticeship and passed examinations, and indeed some physicians took this examination in addition to their own exams.

The most important point however was that the voluntary hospitals were closed to these practitioners; hospitals employed the services only of those recognised by the Royal Colleges, so the distinction between specialists (consultants) and general practitioners had became established. This nineteenth century demarcation in England, but not in other countries, resulted in general

practitioners not only having a monopoly of most primary care, but it also meant that more expensive hospital treatment was based on the outcome of two rather than one medical opinion. This historical accident was to prove a useful barrier to costly and possibly unnecessary hospital interventions, making significant savings for the future National Health Service not available in other countries.

The Society of Apothecaries pioneered improvements in the standard of education and raised the status of practitioners probably more than did the universities or Royal Colleges. Despite all this success, unqualified practitioners still flourished; the 1841 census showed over 30,000 doctors while the first Medical Directory published in 1845 showed only 11,000 qualified practitioners.

The demand arose for a single licensing authority and a single professional qualification. The strongest pressure came from the Provincial Medical and Surgical Association, a body founded in Worcester in 1832 which drew so much support that by 1855 it had changed its name to the British Medical Association. The campaign resulted in the passing of the Medical Act in 1858 which created the General Council of Medical Education and Registration, now called the General Medical Council, one

of its duties being to maintain a register of licensed practitioners.

4.1.4. General Practitioner v Hospital Doctor

The rivalry between General Practitioners and hospital doctors, particularly Consultants has been considerable and the British Medical Association actually felt it necessary to set out terms for the relationship in a code of ethics which made the General Practitioner responsible for his patients while the specialist should be consulted for opinion and advice on diagnosis and treatment. This enabled the General Practitioner to maintain a list of patients without the fear that if any of them were referred to a hospital doctor they would take them over. Echoes of this can be seen in the attitudes of hospital doctors even now and reference is made by Klein (1989:58) to the concept of the NHS as a National Hospital Service rather than a National Health Service;

> "Above all there were the problems of coordination stemming from the division of responsibility as between the hospital the general practitioner and the local authority services. Britain so far, only had a national hospital service. Could this be translated into a national health service."

4.1.5. Bringing the two together

The idea of Primary Care and Secondary Care Health Centres (referred to in Chapter 2 section 2.7)

coordinating the services of the two branches of medicine has been in existence since the Lloyd George coalition was returned in 1918 and set up the Ministry of Health in 1919. The first Minister was a qualified doctor, Christopher Addison. He set up a Council on Medical and Administrative Services under the chairmanship of Sir Bernard Dawson which published a report on proposed reorganization in 1920.

The emphasis of this report lay on bringing together preventative and curative medicine. Consultant advice would be available at the Primary Health Centre, but the main working area of consultants and specialists would be in the Secondary Health Centres, located in hospitals capable of undertaking diagnosis care and treatment of the more difficult case. The scheme considered that most cottage hospitals and some infirmaries could be adapted as Health Centres although rebuilding would be necessary on some scale. Unfortunately a crisis in the middle of 1920 prevented radical reform and the chance of hospital reform was lost and with it the chance of an integrated National Health Service.

In the late 1930's there still existed a division of the hospital service, one section depending upon voluntary subscriptions, the other upon compulsory rates levied by borough and county councils. In the first the doctor was an "honorary" giving his services freely, in the second

he was a paid servant of the local authority. Proposals had already been made to end this separation and dual control, but the difficulties had proved too great and they had never been implemented. On the one hand both doctors and voluntary hospitals feared domination by local councils. On the other hand the powerful and power loving town halls saw no good reason to surrender an important part of their function (Cartwright 1977:172);

> "Only a solution of these problems, acceptable to all, could produce a comprehensive and efficient Health Service of the kind envisaged by Lord Dawson in his Primary and Secondary Health Centres."

The reorganization of hospitals however never involved integration of the two branches of medicine, hospital services and general practice. The concept of multi-disciplinary practices of health care will also be an issue raised later with U.S. practice where some useful lessons may be learned.

4.2. Professional Independence to Interdependence.

In early times the doctor was very much in control, and his authority was unquestioned in the care and treatment of the patient whether in the home or later when the patient might be in hospital. Professional independence was reinforced because for years the centre of his practice had been the home. Hospitals only gradually developed as a place to be when ill and the doctor

continued to guard his position even when the patient was in hospital.

But in the second half of the twentieth century hospital and medical treatment advanced and become much more complex. There are now often large numbers of people involved in treatment, as well as complex laboratory and clinical facilities such as Pathology, Histology, Chemical Pathology, Haematology, Radiology, Radiotherapy, Nuclear Medicine, Audiology, Physiotherapy etc. As the organization has grown in size so there has been a move away from professional dependence to professional interdependence. All this has occurred with a simultaneous development of professionalization of many of the other hospital departments, especially nursing, technical staff and administration. In medicine there is a problem of coordinating all these proliferating specialities which have arisen out of medical research and practice, in addition to the bureaucracies that have grown up around them.

One problem appears to be the lag time in acceptance of these developments by doctors. In the past the doctor's responsibility to the hospital was rarely made as explicit as his responsibility to the patient. It is the confusion arising from this dual role which is partly responsible for creating stress in the system. As Rosen (1972:289) says:

> "One may say that the Industrial Revolution has finally caught up with medicine, and that the medical practitioner is being brought into the "factory" (the hospital and the whole bureaucratic complexity for the provision of medical care) where he is being subjected to the necessary "labor disciplines"."

And during this time as the hospital has become more complicated there has been a growth in stature of the administrators and managers for whom there is also the problem with the medical staff of trying to maintain the rights and goals of the institution, while at the same time trying to preserve the professional rights of the doctor (Warden, 1991);

> "They struck a blow for their craft that clinched the new managerial hierarchy in the hospital service and should cause rueful reflection in other professions, not least medicine, which now find themselves on the sidelines."

4.3. The Power of the Profession.

There are particular characteristics necessary to transform an ordinary occupation into a powerful profession. Two core characteristics described by Wilensky (1964) are esoteric knowledge (experts with a client) and service ideal (ethic), in which altruistic motives eclipse simple greed and the threat of exploiting a monopoly of specialist knowledge.

Schon (1983) describes how the professions have become an essential part of the workings of a modern society. Many of the principal functions are carried out by specially trained professionals, in war, defence, education, medicine, law, managing, designing and construction etc. We look to these professionals for the solutions to many of our problems and in return we have given them rights and privileges.

For the medical profession its apparent expertise and self disinterest ensured that it was given major responsibility for health service resources as the expanding welfare state put money into health care; Klein (1989) states;

> "Implicit in the structure of the NHS was a bargain between the State and the medical profession. While central government controlled the budget, doctors controlled what happened within that budget. Financial power was concentrated at the centre; clinical power was concentrated at the periphery."

Who were given the task of organising those professions supplementary to medicine. According to Schon (1983 and 1991),

> "The greatest achievement in the two immediate post war decades was to win general acceptance for itself professed altruism and expertise which also brought it new found wealth status and expertise."

Patients had to assume that the physician put their interest before his own. Sumners says (1981);

"This power is legitimized through the stereotype of altruistic doctors serving humanity, helping to quell one of the Four Horsemen. Perhaps the more common stereotype is that of professionalism. The physician's prerogative, furthermore, is protected through the institutionalization of medicine. Within this framework is taught the sense of professionalism, that the patient's interests come before one's own."

There are however, signs of an increasing crisis of confidence in the professions generally. With failures of professional action, unanticipated consequences of action, sometimes worse than the original problem, and examples of widely conflicting advice from the professionals themselves. All of this has resulted in a loss of faith in professional judgement, a reaction to blame the professions, and calls for more external regulation of professional activity, and a general questioning of professional rights and freedoms which has now led to scepticism and attacks on the professions.

In 1962 John Kennedy, speaking at Yale, made a number of references to "a second scientific revolution" and "a knowledgeable society" (Lane, 1966) "a post industrial society" (Etzioni, 1967) "organized around professional competence". By the 1970's understanding began to lag, unsuitable remedies began to appear and professional dilemmas became a norm. A series of crises, such as deteriorating inner cities, poverty, pollution, and an energy crisis all seemed to have roots in science. Scientists and scientifically trained professionals found

themselves in the unfamiliar role of villains. The public image of the professionals was becoming tarnished. They seemed like everyone else ready to plead their special status and put it to private use. Public confidence had begun to erode.

Professionals had claimed to contribute to social well being, to put patients' needs above their own and hold themselves accountable. But they now stood accused of serving themselves, ignoring their public service and failing to police themselves effectively. It might be argued that the profession has brought this on itself by not policing itself adequately, not the policing of members' conduct through the General Medical Council but by being resistant to cost effectiveness and proper evaluation of treatments.

It was, after all, only by government pressure that the colleges and specialist bodies began to insist on the profession beginning to participate in medical and clinical audit. It is the culture of professionals that they preserve their own identity and their own freedom yet they are part of the organization with colleagues supporting them. According to Handy (1985) they recognize no boss. Management is a household chore and a manager is accorded by them, to have the low status of an administrator amongst prima donnas. They do not receive orders willingly. Each wishes to be king of his own

domain. One enters that domain by invitation, and command by consent. The administrator governs with the consent of the governed. Co-ordinated effort becomes an endless process of negotiation.

But for a doctor the individual is not subordinate to the organization. Ask a doctor what he does for a living, he does not say, "I work for St X hospital," the reply is always, "I am a doctor, a physician, a surgeon, etc." Not one of the doctors in this study replied otherwise. The organization exists to help the individual achieve his purpose. They are a collection of individuals loosely gathered together, not mutually interdependent, and the organization remains largely unchanged even if one or two depart. It is their talent which is the essential asset of the organization.

They are hard to influence since they do not conceive of themselves working for the organization. Influence and change suggests infringement of liberty. Managing them, has been described as "like herding cats", (Bennis, 1992). They value freedom to speak and act as they wish. They like to be consulted and have the right of veto. They are loners who do not really wish to work in the organization at all but do so purely for convenience. Bennis (1992);

> "Trying to lead doctors is like leading an academic community. It's organised anarchy. Doctors are

> independent and autonomous, and the very reason they selected medicine was because of their fierce desire for autonomy."

Professionals do not like to be managed with all that management implies. The professions do not use the word "manager" for their high status roles, preferring instead President, Dean, Senior Lecturer, Clinical Director, Head of Department, etc. Management is synonymous with office management and housekeeping roles, the administration of the system. To the managers it is illogical to put the controls in the hands of the professionals but to the professionals it is insulting and degrading to have it any other way. The system now appears to doctors to be overmanaged and underled.

Some professionals have become aware of the complexity of the management of medicine itself, and they can see a larger system and a tangled web that traditional medical knowledge cannot untangle. Professionals are being called upon to perform tasks for which they have not been educated. And even if their knowledge did catch up, the result might be transitory as the situation is inherently unstable. The gap is changing, the body of knowledge is changing and the expectations of society are changing. This places on the professional a requirement for adaptability. The role of doctors will continually be reshaped by reorganization and rationalization.

Ackoff (1974) observed that managers will not be confronted with independent problems but with dynamic complex systems of changing problems that interact with each other. He called such situations "messes". He went on to say that managers will not solve problems but manage messes.

4.4. The Decline in the Profession's Confidence.

Some professionals have been critical of their own failures to solve social problems, and many have written on the failure of the health care system to keep pace with the expansion in medical technology. Some have also noted a new trend towards deprofessionalization, a decline in status and working conditions and a pattern of institutional change variously called "bureaucratization", "industrialization" and "proletarianization" of the professions. Professionals are unionizing in recognition of their status as workers rather than autonomous managers of their own careers.

This crisis of confidence in the professions and the decline in professional self image seem to be rooted in the growing scepticism about professional effectiveness, in doubts about the professions' actual contribution to society's well being, and the question of professional knowledge and whether this is adequate to solve the problems which it has helped to create.

Sociologists usually point to Freidson's "Profession of Medicine" (1970) to mark the point when the image of the medical profession began to tarnish. The success of the profession was not due to the above mentioned characteristics, but rather to the degree of control the profession had managed to establish over the conduct of its own work. Medical power therefore rested on a high degree of autonomy in clinical work, which medicine claimed as its natural right. And I have devoted the whole of the next two Chapters to the question of Clinical Freedom or Clinical Autonomy.

In maintaining control over clinical work the profession established control over the distribution of health care resources, and created a special position for itself, according to Klein (1989:28);

> "Most important perhaps for the future, the medical profession obtained a monopoly of legitimacy among the health service providers: a unique position, reflected in the participation of doctors in the running of the NHS".

Successive governments that have provided these resources became increasingly frustrated that their priorities, such as the care of the chronically sick, were frequently ignored. Thus from the mid 1960's the government began the first of a series of attempts to reform the NHS which in retrospect can be seen as attempts to curtail the

control that the profession had over health resource allocation. Gradually, under the pressure of this the image of the profession was transformed from a bastion of altruism to another more powerful image of vested interest.

Despite the American Medical Association's rejection of socialised medicine because of its supposed threat to medical autonomy, the British doctor by and large still maintains more freedom of action than his American counterpart. Although on the other side of the Atlantic they feel the reverse to be true.

So that very same process that now threatens the freedom of action of the profession in Britain has already had considerable influence on health care provision in the U.S., and clinical autonomy there has suffered a similar decline over the past two decades. There it has been the funding bodies - whether government, insurance companies or employers - who have attempted to contain runaway costs by placing more and more restrictions on clinical freedom.

Thus American doctors find themselves increasingly working to guide lines as laid down by corporate and government sponsors. It has been argued therefore, that the profession in the United States is being de-professionalized, as doctors lose clinical autonomy and

simply become agents or employees of corporate providers of health care.

Now similar forces are at work in Britain in the NHS. The most recent proposals for reforming the health service offer the severest challenge so far to clinical autonomy, in that it is proposed to remove many medical decisions from doctors and give them to managers who will act according to market forces. According to Strong and Robinson (1990) even as far back as the Griffith reorganization

> "it was general managers, not the clinical trades, who were now to decide on the division of labour, on the training, on the structure and the measures that were needed, on appropriate individual performance. The old coalition of separate but equal professions was dead."

and again:

> "Where once there had been guaranteed seats on the board, doctors and nurses were now pushed aside to make way for the new general management. GP's and consultants disappeared from the team."

The power of the profession over the past century has been based on doctors organising themselves into a system of collegiate control and then applying pressure to gain considerable freedom over the content of their work (Johnson, 1972). Before this, when patient patronage was the norm the profession was much less powerful or unified. Increasing government intervention into the way

health care is provided means a return to a kind of (government or corporate) patronage in which professional power is again reduced or destroyed. As managers threaten the profession's control over its work, the introduction of more market forces may challenge the unity of the profession. At the same time while fighting to maintain the gains of professional status the profession must also contend with those other groups which have emulated it in pursuing professional strategies of their own and are starting to break free from medical tutelage (Larkin, 1983). There is also the major internal threat of increasing polarisation of the profession between hospital and general practice. General Practitioners from being second class citizens, have rapidly improved their position and may further their control over the hospital sector with the NHS reforms. The General Practitioners want and defend their separate independent status. They are politically powerful and have no desire to yield their autonomy (Enthoven, 1985).

This accentuates the problem caused by the primary thrust of cost containment falling on the hospitals. They are the health care industry's most conspicuous cost centre. But Sumners (1981) argues that the causes of high hospital costs are basically external to the hospital, the consequences of factors outside even the health care industry, the hospital is merely the most visible point

of their emergence. When confronted with situations involving illness people want medical intervention to disregard cost. To be accused of concern with money when health is at stake is a powerful moral sanction; the psychological imperative is to provide care, regardless of cost. He also continues his argument with the idea that a charitable or non profit organization precludes concern over cost. People assume an unidentified "they" will pay.

4.5. De-professionalization.

So instead of being part of the general movement to professionalize everyone the medical profession now faces the threat of de-professionalization. The response can only be to recognize the new climate and accept certain limitations on previous concepts of clinical freedom. Doctors have to learn that a satisfied patient is as important as a medically improved patient.

Weisbord and Stoelwinder (1979) note that physicians have limited interest in the improvement of administrative functioning and often fear that better management may result in limits to their professional autonomy. Migue and Belanger (1974) find demand for health care services to be high primarily because "of [a] patient's inability to evaluate the product he consumes."

Summers (1981) says that patients must assume that the doctor puts their interests before his own. The abrogation of the consumer's ability to assess the quality of treatment gives the doctor tremendous power. Illich (1976), in describing this ignorance on the part of the consumer or patient, suggests it gives doctors a power which renders them almost godlike. In Illich's opinion, the doctor is given moral sanctions which enable him to define illness, thereby granting him considerable authority over those subject to medical examination. Yet even then Illich's description seemed somehow overstated (Sumner, 1981).

There is a rebirth of interest in craft, artistry and myth. The dilemma that afflicts the profession hinges not on science itself but on the post positivistic view of science. There is an irreducible element of art in professional practice. The situations of practice are unique events. It has been claimed that 85% of problems seen by a doctor are not in the book. The unique case calls for an art of practice. There is no satisfactory way of describing or accounting for the artful competence of practitioners. Hoffenberg (1991), drawing attention to the qualities needed "through the current phase of mutation in British medicine", recalled that in the Act of 1512 which foreshadowed the founding of the Royal College of Physicians reference was made to:

"the Science and Cunning (that is, the Art) of Physick...to the perfect knowledge whereof be requisite both great Learning and ripe Experience"

Unable to make sense of the processes in professional knowledge, artful practice of the unique case appears anomalous. Problem setting has no place in a body of professional knowledge concerned exclusively with problem solving.

The systematic knowledge base of a profession has to have four essential elements: specialized, firmly bounded, scientific and standardised. Medical Education in the first two decades of this century, when medical schools devoted the first two years of study to the basic sciences, chemistry, physics, pathology, - thus there was a separation of the medical school curriculum into pre clinical and clinical, reflecting the division between theory and practice.

A dominant view of professional knowledge is that of application of scientific theory and technique to the problems of practice. This is the heritage of Positivism, the philosophical doctrine that applied the rise and achievements of science to the well-being of mankind. The history of the West has been shaped by the rise of science and technology, and the professions have been the vehicles for its application. Medicine, a learned profession with origins in the medieval universities was

refashioned in the new image of a science based technique for the preservation of health.

4.6. The Doctor Patient Relationship.

Another factor, referred to in Chapter 6 on the consequences of clinical freedom, is the relationship between the doctor and his patient which can be one of two types.

Personal practice is the type of medicine until recently provided by the National Health Service. The individual clinician is responsible by name for service to the patient. Indeed his name and reputation may be at stake in the practice of his work. He can invoke no external person to explain his actions. This characteristic and doctor independence is assumed to guarantee that the patient's doctor will always do the best he can for that patient. That resources may be limited is not at issue and can be accepted by doctors and patients, albeit reluctantly, so that treatment thought to be desirable may have to wait possibly indefinitely. At least the patient can see that his doctor is doing the best for him within available resources.

What may now disturb the patient is that the doctor is being instructed in advance what options are to be

considered. Personal medicine is free to adapt to change because it is dictated by the doctor's judgement.

Developments will be slowed if this mechanism is changed particularly as medicine is not static; things are constantly changing and stifling personal practice will only serve to suppress change.

Agency practice is provided in Public Health, School Medical and similar Health Screening activities. Here the work of the doctor can be restricted, whether it be his field of work, his responsibilities, his decisions or even his range of treatments. He can have work, and work targets, set in advance. He can be instructed to carry out any one of a range of options for treatment.

The new contract for GP's introduced by the government can be seen to undermine personal practice, and current changes in hospital medicine are having a similar effect. Agency medicine is encouraged by waiting list initiatives and block contracts. Yet lip service appears to be paid to the importance of personalized medicine by managers and politicians alike.

The government are perhaps totally unaware of this subtle change from personal to agency medicine. In seeking stricter controls and enforcement of these controls with the view that it will reduce waiting lists and give the

population what it needs, it may have introduced a more radical reform not only of the Health Service but also of British medicine. The long term effects may be less than desirable, not perhaps what the government intended, not what doctors wanted, and almost with certainty not what the patient expects.

CHAPTER 5

CLINICAL FREEDOM

5.0. Introduction

In previous chapters I have made several references to the notion of clinical freedom, a concept of major significance to doctor's participation in decision making, management and change. It has a pivotal role in the relationship between doctors and managers. The management of the professions is a key issue in the running of a health care organization, and is an issue to be addressed in a later chapter; for the present however I wish to consider in greater detail the whole concept of clinical freedom.

5.1. The Importance of Clinical Freedom

I have described in earlier chapters how clinical freedom has been enlarged so, for example, the doctor no longer has to worry about the patient's ability to pay before deciding on treatment. And I have shown how this freedom is seen by doctors to be under threat from a government which wants them to be more accountable for their work, and a government which believes it is trying to strike a balance between organization and freedom. As Griffiths (1983) put it;

"Involve the clinicians more closely in the management process, consistent with clinical freedom".

5.2. Descriptions of Clinical Freedom

Clinical freedom is the favoured term; however clinical autonomy is the more accurate description. As many of the participants in this study refer to it as clinical freedom, and this is the popular expression, many not recognizing the term clinical autonomy, I shall continue to use this form although freedom is not the ideal word to describe the concept. Alternative words to freedom are autonomy, liberty, autocracy, sovereignty or independence, of which the latter would be perhaps the most appropriate.

There are limits to freedom even in a doctor's independent practice. Limitless freedom is also an impossible concept. If the limits are exceeded or infringed, the penalties and sanctions which may be brought to bear can be readily and explicitly defined, and include the restraints of the criminal and common law, the limits of acceptable professional practice including the guidelines set by the General Medical Council and, in the case of employees, the limits, explicit or implicit, within an employment contract as well as the constraints of the National Health Service or local Health Authority or Trust. So freedom does not seem

to be a very germane word, but popular and common usage make it difficult to change.

Further study and enquiry began to suggest the possibility that clinical freedom as it was commonly used in the National Health Service was not in fact a single concept but a group of concepts. Such a possibility would go some way to explaining certain people's instinctive sense that some consultants in the NHS had always been more clinically free than others

Tolliday (1978) has written in some detail on clinical autonomy in the National Health Service. She feels that there appear to be two commonly held assessments on the constitution of clinical freedom: either that doctors have it by the very nature of medical work and that the medical culture is inconsistent with making a doctor subordinate to a manager, or that doctors and only doctors legitimately command clinical freedom. Indeed the Merrison Committee (1975) stated that the argument was widely accepted in the NHS that doctors cannot be managed because of the damage such an arrangement would cause to medical self respect and dignity and there was a need to maintain the self respect of the profession.

An alternative view is that consultants have clinical freedom in the National Health Service, firstly because of the nature of illness itself, and secondly because of

the determination in the National Health Service to provide health care through confidential relationships between doctors and patients, that is to say to provide a personalized service as opposed to an agency service. This is an issue to be addressed later in this chapter. It is this determination, and the need for clinical freedom which follows from it, that makes it impossible for consultants to be subordinated to a manager. Not having a manager does not mean however that doctors in the National Health Service are free to do just as they please. Control mechanisms have been set in place which set limits upon the work which consultants undertake within the National Health Service.

A consideration of these two views suggests perhaps that the concept of clinical freedom embraces not one or two, but several features which might be unravelled for separate consideration. Clinical freedom as commonly used in the National Health Service has many distinct and separable elements and I feel that rather than just consider all the elements separately it would be helpful first to group them under the headings of those elements which embrace the idea of clinical freedom, and secondly those elements which, although part of the concept, are nonetheless in reality, rather more arguments for retaining clinical freedom, and lastly to discuss some of the implications of clinical freedom.

In the first group those elements which make up clinical freedom include independent practice with unmanaged status, patient choice, practitioner choice, primacy and prime responsibility. Personalized service, medical dignity and the nature of illness are more to do with the second group.

5.3.0. The Elements of Clinical Freedom

5.3.1. Independent Practice with Unmanaged Status

This allows the doctor to use his judgement without it being subject to scrutiny and modification by anyone else. The right to independent practice rules out management of the practitioner by a manager carrying responsibility at a higher level for the work carried out. Independent status is sometimes alleged to amount to doctors being endowed with enhanced or special status in society. However independent status can be justified to provide the patient with the personal confidential doctor patient relationship thought to be essential for the anxiety of illness.

There is also the question, whether doctors in general, (although not exclusively, as access for instance to dental care is an exception), act as the gatekeepers to the National Health Service. A medical qualification may equip the holder to understand the needs of the patients

in totality better than any non medical professional qualification. But such an assumption is increasingly being challenged in health care in the National Health Service, and to the extent that it is not a single field of care but separate fields of care, does complicate the allocation of the elements of clinical freedom to professional roles.

5.3.2. Patient Choice.

Clinical freedom entails the right of the patient to choose his practitioner or doctor. This is called patient choice; the relationship is personal, freely entered into and based on confidence and trust. In general practice patient choice is more explicit than in specialist practice where for a consultant the principle of patient choice is not so clearly established. In reality such choice is usually limited to the practice of the patient's general practitioner choosing a particular consultant on the patient's behalf, allowing the patient to state a preference for a particular consultant or to grant the patient's right to ask for a second specialist opinion.

The preservation of clinical freedom, including freedom of the choice of doctor within the resources available, can ensure for the patient the same degree of personal quality and confidentiality of care under a national

service as under other types of service. The patient has in effect a personal doctor and it is for that doctor to handle the bureaucracy on the patient's behalf.

5.3.3. Practitioner Choice.

In addition the doctor has a right to refuse an individual as a patient. According to Enthoven (1985);

> "In the name of clinical freedom consultants can choose the kinds of cases they want to see, accept or refuse referrals, arrange their operating schedules, pursue their intellectual interests independently of patient needs, and keep patients waiting for months",

although in the National Health Service this right is to some degree limited by the terms of service of most medical practitioners. Klein (1985) discussing the decision making autonomy of clinicians says:

> "..clinicians are free to determine whom they select for treatment and how they treat them."

And Light (1991) in his observations of the National Health Service, and the work of Pope (1991), on waiting lists, reinforce the idea that consultants may use considerable choice in who they treat;

> "They are not a first come, first served queue but more like a singles dance, where (simply) the gals whom the guys pick are determined by what the guys are looking for, how much time they have, and how skilfully or persistently the chosen put themselves in the minds of the choosers".

While such researchers may be able to identify examples of this, my study suggests that usually, and I am primarily referring to surgical waiting lists, patients were before the 1989/90 reforms admitted in chronological order according to strict clinical priority and need, with an additional case mix adjustment according to the needs of training for junior doctors. The introduction of the internal market has largely changed that to one of selection according to the priority or ability of the purchaser to pay (i.e. the Health Authority or General Practitioner Fund Holder). The consultant remains in the position, however, of assessing priority of an individual case within a group contract.

5.3.4. Prime Responsibility.

Health care is rarely now within the competence of a single profession, and when ensuring those professions who may be able to contribute to a patient's investigation, treatment and care are made available and that they are all co-ordinated effectively, the normal practice is to allocate prime responsibility for the care of each patient to a specified practitioner. Prime responsibility may of course be re-allocated from one practitioner to another.

In the situation of medical treatment in hospital, whether as an inpatient or outpatient, many members of a variety of professions are often involved in the investigation, diagnosis and treatment of a particular case, but the consultant who has prime responsibility is ultimately in charge of the case. He co-ordinates the actions and discussions of all those doctors brought into the case and ensures that all the underlying needs of the patient are met. Jaques (1978) sets this out neatly under two headings, firstly that it will be necessary to make an assessment of the general needs of the patient at the time of assumption of prime responsibility, to undertake any action needed or to initiate such action, through junior medical or ancillary staff, and to refer when necessary to colleagues and other professionals for collaboration in further assessment or action or for action in parallel, while remaining continuously aware of the progress of the case and taking further initiatives as necessary. In other words this is a co-ordinating rather than a managerial role. And secondly the doctor with prime responsibility has a right and duty to decide when to relinquish extended collaboration with colleagues or when to terminate all further action on the case. However as he points out this is probably only true for personalized medicine, an issue to be addressed later.

In this context it is worth noting that difficulties do arise in linking clinical freedom to particular roles.

For example consultant radiologists and pathologists do not fit the criterion agreed for clinical freedom. Many of them do not have their own patients but always work on problems presented by doctors carrying prime responsibility for the patient, i.e. usually a clinical consultant. They only perform tests upon receipt of a written request; if they feel that further investigations or tests are required they only advise on this. It is then for the doctor with primary responsibility to decide whether to write a further request for additional investigations. Nonetheless all groups of doctors were afforded clinical freedom although as a group they fail many of the criteria associated with the concept. They do not have primacy, prime responsibility, nor do they provide a personalized service or have a personal relationship on a named basis with patients.

There are therefore certain doctors who regularly carry prime responsibility as defined above and others who do not. In general it includes all who can talk about "their" patients, general practitioners, surgeons, physicians, psychiatrists etc. Anaesthetists, radiologists and pathologists are unlikely to carry prime responsibility. There are however exceptions such as haematologists investigating and treating patients with blood disorders, anaesthetists treating patients in intensive care units and pain clinics etc. By and large there appears to be a very well developed etiquette in

medicine itself as to who carries prime responsibility in any case and at what point it transfers, but there are significant pockets of doubt, such as consultants and general practitioners regarding, for example, patients in cottage hospitals. Rowbottom R.W. et al. (1973). It seems therefore that the automatic allocation of prime responsibility as so far defined must always be limited to some particular field of work.

Jaques (1978) summarises prime responsibility:

> "In a situation where many members of a variety of professions are involved in the consideration of a particular case, the practitioner who has prime responsibility is ultimately in charge of the case. He co-ordinates the actions and discussions of all those practitioners brought into the case and ensures that all underlying needs are met. More specifically he has co-ordinating but not managerial authority to:
>
> a. make a personal assessment of the general needs of the case at the time of assumption of prime responsibility.
>
> b. undertake personally any action needed or to initiate such action, through subordinate or ancillary staff.
>
> c. refer, when and as necessary to colleagues and other independent agencies for collaboration in further assessment or action or for action in parallel.
>
> d. keep continuous awareness of the progress of the case and take further initiative as necessary.
>
> 2. Further, although it may not be true for agency service, where the practitioner with prime responsibility is in independent practice he has the right and duty to decide when to relinquish extended collaboration with colleagues or when to terminate all further action on the case."

5.3.5. Primacy.

The idea of primacy springs from prime responsibility. Cang (1978:94) defines it as the automatic allocation of prime responsibility. According to Tolliday (1978:44);

> "Where one profession is held to have a more encompassing and comprehensive knowledge of all the fields of care available in the National Health Service than any other discipline or profession, such that prime responsibility automatically falls in the first instance to a member of that profession. Thus that profession may be said to have primacy."

It is only doctors who have primacy in the National Health Service. Dental care is however one exception where the dentist usually carries out all his own treatment. The identification of independent practice, primacy and prime responsibility as separate components of clinical freedom, however, make it possible to recognize that the apparent influence and power of doctors and consultants arose not so much from their status as from their primacy. Tolliday states (1978:45) "they make the National Health Service what it is". They are the group authorized to determine who shall be patients and who shall receive the services of the National Health Service, and are further empowered to determine what skills other than doctoring skills are appropriate to the care of those defined as patients.

Furthermore primacy always remains with the doctor, even though he may transfer at his discretion care to other professions, and even the prime responsibility for that patient care to members of other professions.

5.4.0. The Reasons for Maintaining Clinical Freedom

5.4.1. Personalized Medicine

A prime reason for the retention of clinical freedom for consultants was in order for patients to have the continuing right to a confidential, personal relationship with their own particular named doctor. A personal, private and confidential relationship between doctor and patient is built on the clinical freedom of the doctor. Full clinical freedom contains a number of constituents, all of importance to the patient, namely his independent practitioner status and the carrying of prime responsibility by the doctor and mutual patient doctor choice. Clinical freedom ensures doctors work as independent practitioners who are then free to diagnose and treat in accord with their own best clinical judgement and in the best interests of the patient.

I have already discussed in Chapter 4 Section 6 how the individual clinician is responsible by name for service to the patient, and the consequences that flow from that for the doctor patient relationship. Society has placed

confidence in the individual clinical judgement of a highly trained and selected group of people, relied upon as professionals, given genuine freedom but not absolute licence, freedom within appropriate limits, fixed by law, including explicit National Health Service policies and the requirements of the General Medical Council.

Cang (1978:92) argues that this independent practitioner status precludes consultants from having a managerial superior. They are managerially freestanding, working within the very broad terms of reference established by their contracts with a Health Authority or Trust. The quality of their clinical work and decisions is not subject to managerial scrutiny or review unlike junior doctors who are in a manager subordinate relationship with a consultant, although this may not be overt. These ideas may make managerial control of consultants problematic, but whether they make it impossible is open to debate.

Medical audit does not supplant clinical autonomy although it is sometimes thought to do so if it only ensures that a doctor stays within policy limits.

Doctors have clinical autonomy in the National Health Service because, although care is state provided, the policy for National Health Service care is that of personalized care. The patient has his own doctor in whom

he can place his trust and confide the most intimate of his desires, fears, and secrets without anxiety that such information will become public property for use other than in the management of his illness.

It is the policy of providing personal care of this kind that largely, if not entirely, gives doctors their right to unmanaged status. In other words clinical freedom is directly linked with the work of the medical profession and not with membership of the medical profession. Thus perhaps only those doctors providing personal clinical services, including some consultants, should have clinical freedom and its associated unmanaged status. Clinical autonomy, far from being a matter of concern only to doctors, is crucial for patients, if they are to continue to have personalized care.

5.4.2. The Nature of Illness

Traditional sociological thinking has justified the unmanaged status of doctors on the grounds of possession of esoteric knowledge and skills. In the discussions concerned with establishing management arrangements for the reorganized National Health Service, some doctors have argued vehemently that they should retain their clinical autonomy because of their professional status. Tolliday (1978) feels;

"exploration of some of the practical problems arising from general and sociological explanations of doctor's clinical autonomy had lead us to the realization that the real reason for the NHS's retention of clinical autonomy for doctors, despite the attacks on it, was far more important than anything related to doctors' self interest or self esteem: that reason lay in the nature of illness and arising from that, the form of health care most likely to benefit the patient."

5.4.3. Medical Dignity

One argument widely accepted in the National Health Service is that doctors cannot be managed because of the damage such an arrangement would cause to medical self respect and dignity. Reference has already been made to the Merrison Report (1975) which spelt out the need for the medical profession to maintain its self respect.

If the dignity of the profession as a whole and individual members is at stake, it is difficult to see how any government can allow doctors to be managed.

Much of the writing on the creation of the National Health Service assumes that doctors' clinical freedom was built into the service because the medical profession wanted it so and the government of the day was not strong enough to refuse it. Foot (1962), in an account of Aneurin Bevan's negotiations with the medical profession in the 1940's, suggests that doctors' clinical freedom and unmanaged status in the NHS was the price the government had to pay to get doctors to enter into the

health service in the first place. In such accounts, clinically autonomous practice was seen as consistent with a contract for service between doctor and patient where the patient pays, but inappropriate to practice where the state, and not the patient, employs and pays the doctor. In other words, the argument runs, doctors have clinical autonomy in the National Health Service because they insisted on practising in a state provided health service in an identical fashion to the way they practice privately. Clinical freedom in the National Health Service is thus seen to be an anachronism and anomaly, only preserved because of the preference and power of doctors.

In the face of a radical reorganisation embarked upon in the 1989 reforms the doctors were ardent defenders of a nationalised structure. They had taken refuge in the doctrine of central control, i.e. regional appointments for consultants and uniform terms and conditions of service to avoid interference from local authorities. The medical benefit societies had gone, as had the spectre of municipal control of doctors. Clinical freedom had been increased by the formation of the National Health Service. Honigsbaum (1990);

> "Clinical freedom had been enlarged as well, as the doctor no longer had to worry about the patients ability to pay before deciding on treatment. The profession was enjoying greater freedom than at any time since club practice began in the 1820's."

According to Tolliday (1978);

> "Thus far then employment in the NHS has curtailed medical practice no more than it is curtailed when undertaken privately."

Although that probably is no longer the case as cost controls have become ever more explicit. Even in the 1974 reorganization Klein (1989) felt that,

> "In the case of the medical profession, the new managerialism presented a potential threat to their clinical autonomy as traditionally conceived, their immunity from scrutiny appeared to be at risk. In short the basis of the implicit concordat on which the NHS was founded - that ministers would decide on resource levels while consultants would have complete autonomy within any given budget - seemed to be in the process of being eroded.....No wonder too, that the medical professions sense of insecurity translated itself into low morale and a tendency to see the chronic shortcomings of the NHS as an acute crisis. If rationing by consultants had always been a fact of life in the NHS, it was perhaps becoming less attractive to accept responsibility for it during the second half of the 1980's and more tempting to blame the government".

A sense that doctors' clinical freedom is vulnerable in the NHS has been increased with the expansion in the number of separately established professions in health care during the last ten years or so. The assumption in the Service that clinical freedom is in the gift of the medical profession, and is awarded to all its members, means that if other professions reach maturity and full professional status, they too will expect their members to have full clinical freedom. Such an eventuality would

appear to present the National Health Service with an impossible management problem. One way to avoid this would be to deny everyone clinical freedom. It is this scenario which many doctors most fear.

5.5. The Implications of Clinical Freedom

Providing health care on the basis of a personal doctor patient relationship has profound consequences for the organization and structure of the National Health Service. Because of the emphasis on accountability in the service, many have been in favour of establishing Chief Executive Officers and General Managers carrying responsibility for health services within a hospital or district, in the same way as managing directors in industry. However because of the nature of health care as established in the 1946 Act and based on the personal doctor service, consultants could not be subordinated to a hospital or district Chief Executive Officer or a General Manager.

This does not mean that consultants cannot be made accountable. Confusion seemed to exist in the minds of many people about this, some arguing that consultants could not have managers because of the work they perform. It was also argued that they could not be involved in management, or even be made accountable.

Clinically autonomous practice, whether in the private sector or within the National Health Service, is not entirely free practice. All doctors are accountable for staying within certain limits, the limits established by the medical profession, representing acceptable medical practice, as well as the limits binding on the behaviour of all citizens, and of course financial limits.

As an example the National Health Service, together with doctors, is held liable for negligence. It does not do so through managerial authority however; it uses a monitoring authority, being informed of work carried out, advising doctors where work is contravening limits and, if it falls outside these limits, suspending or terminating the contracts of individual doctors.

There are of course difficulties of such monitoring and these are well known. The binding standards of any profession change with changing social attitudes and technology. The boundaries of acceptable practice are shifting constantly. Speller (1971) in quoting Lord Justice Denning's judgement shows;

> "It would, I think, be putting too high a burden on a medical man to say that he has to read every article appearing in the medical press; and it would be quite wrong to suggest that a medical man is negligent because he does not at once put into operation the suggestions which some contributor or other might make in a medical journal. The time may come in a particular case where a new recommendation may be so well accepted that it should be adopted".

Until recently, employment in the National Health Service curtails medical professional practice no more than it is curtailed when undertaken privately. What has occurred recently however, is that cost control has become more explicit and the limitations of budgets have dictated amounts of health care in a hospital or district. The devolution of budgetary control to the individual faculty or firm has now set financial considerations higher on the agenda for individual consultants than hitherto when considering individual patient care.

To provide for this monitoring of clinically autonomous doctors and ensuring that their practice keeps not only within the limits binding on all consultants but also within the policy and resource limits determined for the National Health Service as a whole and locally, the policies and resource limits have to be such that consultants feel they are allowed to accept responsibility for treatment prescribed for their patients. If these policies and resource limits mean that consultants feel that what they do for their patients is unacceptable, then who carries responsibility? In the words of Tolliday (1978);

> "If prevailing policies leave doctors feeling that what they are able to do for their patients is personally unacceptable, no one carries responsibility."

Ways must to be found to ensure that policies are acceptable. The only practical way is to oblige consultants to gather together to see if they can establish a medical view acceptable to all of them, i.e. what they think of proposed policies or what they themselves wish to propose. This may use the representative principle developed in the past with local hospital medical committees where the consensus views are negotiated through elected representatives, although this role has been subject to change as discussed in later chapters. Indeed the whole of the next chapter is devoted to the effect that the concept of clinical freedom has on the management of consultants.

5.6. Clinical Freedom and other Health Care Professions

Not only has the clinical freedom of consultants been preserved in the National Health Service, but also professional independence in the form of independent practitioner status is being steadily granted to an expanding number of professions within the Service. The issue of liberty thus reappears not only in the retention of clinical freedom for doctors but also in the possible extension of prime responsibility to professions other than medicine. Some members of established non medical health professions began to question the clinical freedom of consultants monopoly in hospital.

To see this in its true context one needs to consider the definition, and the aspirations, of a profession. There have been many attempts to define a profession. There is a considerable body of sociological literature on professions all filled with attempts to find an adequate definition. Possession of a body of particular and specialised knowledge, adoption of a service ethic, existence of a professional association, control of training and testing of competence, public registration, length of training, and many other factors have been given due weight by various commentators (Wilensky, 1964. Goode, 1969. Hickson and Thomas, 1969).

Others claim that the whole attempt to find a rational definition is misguided, that professions are simply those occupational groups who have been lucky or clever enough to negotiate themselves into a situation of high status and power. Johnson (1972). The word profession is significant and must be defined accurately. Clearly the word has everyday currency and conveys something beyond the general term of an occupation. There is in everyday usage an implication that being a professional means bringing specific theoretical knowledge and insight to bear which non professionals do not have, or have in a lower degree, in the process of assessing real needs and appropriate responses. There is also an implicit expectation that the true professional will exercise his own judgement in particular cases as impartially and

objectively as possible. In other words there is the implication of some kind of ethic. One question stands above all others in the demands of disparate groups to share the privilege of clinical freedom. These are the demands of other professionals for clinical freedom based on a wish to enjoy a confidential one to one relationship, or maybe they merely desire unmanaged status.

To the extent that the answer to this question is not relevant to this thesis we need consider the matter no further, but to the extent to which the issue has been raised as stated indicates the problems to which the National Health Service is subject, namely that if the increasing demands for clinical autonomy in the National Health Service by other professional groups are successful and if they are based on demands for unmanaged status rather than the other precepts of autonomous status, then the problems of managing the organization will increase.

CHAPTER 6

THE CONSEQUENCES OF CLINICAL FREEDOM

6.0. Introduction.

The National Health Service is not only a very large organization, it is also an extremely complex one. Much of its complexity arises from the provision of personalized rather than agency health care and from the multi-professional nature of modern health services. The discussion of clinical freedom has indicated some of the complexities and difficulties this creates within the Service. The association of clinical freedom with the nature of the work done, rather than with the prestige of the medical profession, allows explicit recognition of the nature of illness and the National Health Service's response to it. Further analysis has led to the sorting of elements of clinical freedom and the possibility this has given for professions other than medicine to achieve unmanaged status, indeed for non medically qualified professionals to assume the right to practice independently and to assume prime responsibility.

An analysis of the meaning of clinical freedom has also raised questions about the domains of National Health Service activity, the nature of the boundaries of the professions, their relationships to National Health

Service activity and policies bearing on that activity. As I have shown in the previous chapter clinical freedom is not just about how much freedom doctors should have. It is also about freedom of patients to make choices, as well as choices about the nature of health care.

Elliott (1978) talks about criticisms of a grey mediocre uniformity under a national governmental monopoly service, the serious issues raised, and problems not easily avoided. He lists a number of conditions which must be established if these criticisms are to be answered.

1. patient choice of doctor
2. reciprocal right of doctor not to have a particular patient
3. private and confidential relationship between doctor and patient
4. doctors' right to independent practitioner status
5. avoidance of records on patients unknown or unavailable to patient.

He feels these criteria should apply to any health service, governmentally provided or otherwise, which perhaps reinforces the view that clinical freedom is not just about the interest of doctors. Hayek (1960) states that

"There are so many serious problems raised by the nationalization of medicine that we cannot mention even all the important ones. But there is one the gravity of which the public has scarcely perceived and which is likely to be of the greatest importance. This is the inevitable transformation of doctors, who have been members of a free profession primarily responsible to their patients, into paid servants of the state, officials who are necessarily subject to instruction by authority and who must be released from the duty of secrecy so far as authority is concerned. The most dangerous aspect of the new development may well prove to be that, at a time when the increase in medical knowledge tends to confer more and more power over the minds of men upon those who possess it, they should be made dependent on a unified organization under single direction and guided by the same reasons of state that generally govern policy. A system that gives the indispensable helper of the individual, who is at the same time an agent of the state, an insight into the other's most intimate concerns and creates conditions in which he must reveal this knowledge to a superior and use it for purposes determined by authority opens frightening prospects."

However, the growing independence for other professional groups may make it possible for the National Health Service to move in exactly the opposite direction to that predicted by Hayek. In the words of Jaques (1978);

"Not only has the clinical autonomy of both consultants and general practitioners been preserved in the NHS, but professional independence in the form of independent practitioner status is being steadily granted to a wider and wider range of professions in the service. The issue of liberty thus reappears not only in the retention of clinical autonomy for doctors but also in the possible extension of prime responsibility to professions in the service. The issue of liberty thus reappears not only in the retention of clinical autonomy for doctors but also in the possible extension of prime responsibility to professions other than medicine."

6.1. Management and Clinical Freedom.

Much concern has been expressed by consultants that if they were organized into managerial hierarchies they would lose their clinical freedom as professional practitioners. Given the nature of clinical freedom according to Rowbottom (1978) some of the issues that are encountered are to do with how far external management or direction of professional work is appropriate or possible in medicine. Can doctors be managed by their employers and if so in what sense of the word? Can they appropriately be placed under the control of senior general managers or lay administrators? How far can employing authorities themselves properly guide or direct the work of their professional employees?

Secondly could doctors appropriately manage other doctors without improper interference with the exercise of professional judgement? And thirdly if doctors, for example, have authority over nurses or other paramedical staff, how far should it extend and what justifies that authority? There is no one set of answers which apply equally to all the various occupational groups under consideration.

Rowbottom (1978) identifies four characteristics:

1.Degree of professional development - whether the group possesses its own specific body of theory and practice which has moved beyond the stage where non members can be expected to appreciate emerging possibilities for extension and further development.

2. The practice assumption - whether the assumptions explicit or otherwise of the nature of the practice in any given situation are consistent with what may be called agency service, or whether they demand what might be called independent practice for the individual practitioner.

3. Existence of an "encompassing" profession - whether or not another profession or occupation exists which is regarded as having a deeper or more encompassing view of practice in the field concerned.

4. Primacy - whether members are recognised as automatically carrying prime responsibility where members of other occupational groups regularly work together with them on the same cases or projects.

In considering these characteristics it is useful to develop the ideas with respect to the relationship between the management of the doctor and clinical

freedom. I shall develop further only the arguments with respect to the first two, because the last two I have covered in the previous chapter in some detail as well as clarifying the issues of primacy and prime responsibility, which the above classification has confused.

6.2.0. Degree of Professional Development.

The key question is just how far it is possible or appropriate for a senior administrator, General Manager or Chief Executive to exercise control over doctors. The issue here is not whether they could physically do, with equal proficiency, all the work of those of various specific professions or crafts of whom they are in charge, nor even whether they could give detailed technical instructions to the doctors. The real issue is whether they actually understand enough about the work and the needs which it has to meet, to manage the performers of that work, i.e the doctors. Now one is obliged to clarify what is meant by the word manage, and in this context I shall first use the definition of Rowbottom (1978:74)

> "a manager as someone who is accountable for his subordinates' work in all its aspects, who is not only able to assess the quantity and quality but the effectiveness of the work of his subordinates."

This definition is to some extent supported by Jaques (1976:64) who talks of;

> "the accountability of a manager for the work of a subordinate to his own superior."

Clearly with this definition the more developed a professional group becomes the more difficult it is for a non-member, however generally capable, to perform this managerial function adequately. When a manager cannot help his subordinates with technical problems encountered, where he cannot really judge their all round competence in any precise degree and where he lacks any perception for emerging possibilities of practice or ability to guide the practitioner in important new developments, it is necessary to question in what sense the word manager is being used.

Some hospital managers were willing to assert (privately if not publicly) their collective competence to manage doctors or any other profession in hospitals, however specialised or advanced the nature of their work. However further exploration would demonstrate that these same managers did not mean by this that they would feel able for example to assign priority to clinical cases, allot particular clinical cases to doctors or to make effective assessments of their clinical as well as general abilities. Nor would they feel able to carry full accountability for all aspects of the work of doctors, or

indeed of any other professionals, in the same way that they would naturally do for the work of their own immediate assistants. Nor would they feel competent to guide doctors in important developments in medical practice.

But this is normal for many managers; lack of competence to undertake a task of a subordinate does not prevent a person managing. The main difficulty seems to be in identifying a universally agreed definition of managing. As Boyatzis (1982) states;

> "Having the word manager in one's job title does not necessarily mean that person is a manager."

Appley (1969) defines a manager as

> "someone who gets things done through other people."

In fact Boyatzis (1982), synthesising the work of Appley (1969) and Drucker (1977), describes management as five basic functions: planning, organizing, controlling, motivating and coordinating.

Clearly the managers referred to above were carrying some relationship of control or guidance, even if not gubernatorial authority, in respect of the doctors and other professionals. It is possible to identify clearly

two distinct types of relationship, a monitoring and a co-ordinating role.

6.2.1. Managerial Role.

One managerial role arises where a manager is fully accountable for the work of another or others. The manager is usually expected to help in the selection of X, to instruct X in the role expected of him and to assign work and allocate resources. The manager usually expects to keep himself informed about X's work and help deal with problems. It is normal for the manager to appraise X's general performance and ability and in turn keep X informed of his assessments, arrange or provide training, change roles or arrange transfers or dismissals. Lastly the manager needs the authority to veto the selection of X for a particular role, to make an official appraisal of X's performance ability, and perhaps to initiate transfer or dismissal.

6.2.2. Monitoring Role.

A monitoring role may arise where it is felt necessary to ensure that the activities of an individual conform to satisfactory standards in some particular respect and where a managerial supervisory or staff relationship is impossible or requires supplementing. The aspect of activity to be monitored might for example be adherence

to contract of employment i.e. attendance and hours etc, safety, financial propriety and security, levels of expenditure, technical standards of work or adherence to personnel policies.

The monitor would be expected to obtain adequate information on the effects of the activities of a particular individual and to discuss possible improvements with them or their superior, to report to the manager or superior body any sustained or significant deficiencies, and to recommend new policies or standards where required.

The monitor needs authority to obtain first hand knowledge of the individual's activities and problems, to persuade the individual to change performance but not to instruct. But does not need the authority to make or recommend official appraisals of the individual's work nor to set new policies or new standards. According to Rowbottom (1978);

> "What neither relationship includes is either the right to issue final or binding prescriptions in the face of strongly conflicting views, or the right to make or act upon fine assessments of performance of personal competence, as is expected in the managerial relationship."

One might also question why the roles of certain doctors do not fit the aforementioned facts. Why is it, for instance, that doctors employed as civil servants and

junior medical staff are organized into managerial hierarchies, which it is claimed are absolutely incompatible with the type of work performed by a qualified doctor? The answer to these apparent inconsistencies lies in the nature of the work of doctors in these examples. In the first case the civil servant doctors are not primarily employed as doctors but as civil servants and they have no direct doctor patient relationship and no prime responsibility as a named doctor to a patient; they are not engaged in personalized medical practice. In the second case the junior doctor is only an agent of the consultant, carrying no prime responsibility; the consultant remains the named consultant responsible for the personal medical care of the patients. It is thus possible to see from these exceptions the importance of the provision of personalized medicine in the concept of clinical freedom. This leads to the second of the four characteristics outlined by Rowbottom (1978), the establishment of a strong one to one therapeutic relationship, which argues for independent practice in medicine. For doctors who are employed outside clinical work without an involvement with individual patients, for instance epidemiological work, medical administration, screening or immunization programmes, then the same arguments do not apply.

6.3. The Practice Assumption.

Possibilities for managerial organization caused by the occupational characteristics of medical practice described thus far have significant implications. They affect management, but they do not prohibit some form of managerial control. Either the profession can be incorporated into pre-existing managerial hierarchies, which is the form now being pursued by most hospitals in the UK implementing the new reforms from the White Paper, (1989) or an independent professional managerial hierarchy may be created on its own under the employing authority along the lines that used to exist before the 1974 reorganization. Bureaucratically, management organization is therefore still possible.

A patient arriving in a hospital has their medical care supervised by a particular, identified and named consultant, who is an independent practitioner, employing clinical autonomy and employed to pursue a professional practice as they think most appropriate within the broad terms of a contract.

The patients' have confidence that their doctor has complete freedom within certain broad limits to diagnose, investigate and treat as they personally judge best. Under these circumstances mutual trust is likely to be the outcome. Thus independent practice is linked in this

particular case to the requirement to establish a strong clinical relationship. This in turn implies the possibility of choice, and in the previous chapter I have discussed the freedom of the patient to choose or change his doctor and indeed the ability of the doctor to transfer his patient where a minimal necessary level of trust and co operation cannot be established.

However, there are circumstances, for instance when one psychiatrist or one geriatrician automatically deals with all cases arising from one predetermined geographical area, in which there is no effective choice for the patient. Pathologists, radiologists or anaesthetists in independent practice rarely have patients of their own and patient choice is again usually non existent. The question therefore arises whether pathologists and radiologists etc are in independent practice. There seems to be only one firm ground rule, that of a voluntary relationship of trust and co-operation between a specifically identified professional and a specifically identified patient. Independent practice is therefore the basis of personalized medicine.

6.4. Implications of Independent Practice.

The question of the management of other professionals by non professionals often leads to the comparison of doctors with airline pilots. It is widely accepted that

planes need well trained independent professionals to cope with whatever situation develops. But it is also accepted that the autonomy can be exercised within limits of financial and organizational efficiency set by the airlines (West, 1988). The pilot does not however have a personal, confidential or individual relationship with the passenger. The passengers' do not have a right to personal choice of pilot. Although the pilot is not able to choose passengers the pilot probably does have a right as captain, to put off the plane anyone considered a danger to other passengers. The pilot does not have primacy and although there is prime responsibility while in the air, the pilot's position could be seen as that of an agency service as opposed to a personalized service. It has to be recognized that many patients may not realize that they have this choice of consultant.

Managerial control may be inconsistent with independent practice and therefore with personalized medicine. Where independent practitioners work together there can be a monitoring and co-ordinating relationship. Although doctors may be difficult to manage there is a need to see that they are co-ordinated and integrated with other work and developments. Thus as Clinical Directors emerge, this title implies not so much a managerial role but rather a monitoring and co-ordinating one carrying within it a limited authority and only applicable within the

general terms of any policies or practices adopted by the unit, department or hospital as a whole.

The personal attitudes and styles adopted in the interaction are of course another matter. Having authority does not necessarily mean behaving in an authoritarian way. Indeed the question of authority is addressed in a later chapter. Equally encouraging participation in decision making does not necessarily mean relinquishing authority, According to Rowbotton (1973);

> "..no prescriptive rights exist between doctor and doctor, other than where the second doctor is in training or specifically employed as an assistant."

This applies even between surgeons and anaesthetists or physicians and pathologists.

Even for professionals intent on staying in independent practice however, there are many obvious advantages to working in a larger organization, and a number of ways of arranging this. The professional may find himself working alongside fellow professionals some of whom may be more senior or eminent, but again if independent practice is truly required, this is inimical to the establishment of managerial relationships. Even the employing body itself will have no right to impose particular rules or policies or to demand that specific

tasks be accomplished or that specific methods be followed, unless any of these have been the subject of specific contract negotiation.

The National Health Service recognizes no right on the part of a sponsoring bodies such as a FPC, FHSA, HA, or Trust to tell the professional how to diagnose or treat, or what priorities to give to patients or how to organize their work. And although hospital consultants are actually in the salaried employment of HA's or Trusts who provide their premises, supporting staff, equipment and materials, they too recognize no constraints on work that are not the subject of specific agreement.

Doctors are usually grouped with fellows into divisions or departments and firms, and it is usual for a senior member chosen by the group itself to act both as spokesman to the external world and as a co-ordinator within the group. However the role of such elected representatives has many limits and in no way can they be held accountable by the employing authority. In addition there will need to be certain designated senior staff, not necessarily of the same professional group, who act unequivocally as agents or officers of the employing authority with the job of carrying out such additional and broader focussed co ordination as is necessary, as well as monitoring adherence to contract conditions.

Where a number of distinct specialities exist, questions on how many should have separate representation to speak and negotiate on their behalf may arise. How many specialities should be banded together? It is difficult for non members of any distinct professional group or sub group to be able to command adequate understanding of the specific needs and emerging possibilities for new developments and so to act as effective spokesmen.

As any profession develops, it will be natural for members to seek to interact with one another through specifically formed professional associations to put forward the development of their common practice and knowledge. This is over and above any desire to associate to protect their collective interests, a desire which they may share with less well developed occupational groups. Second it will be natural for them to begin to take an increasing interest in training and the setting of qualification for practice. Thirdly they will tend to want control of their own practice development in specific organizations where they are employed in large numbers. They will look to the establishment of management posts to be filled by their own members and the direct access of such members to policy forming bodies.

The gathering together in recent years of all social workers in social services departments, headed by

directors who are increasingly chosen from the ranks of qualified social workers themselves, suggests recognition that social workers too have now reached a stage of professional development which prohibits effective management by non members.

One issue that seems appropriate to raise now is that a professional manager has to work within a professional code of conduct whereas a non professional manager or administrator has no such code (Heys, 1991);

> "Managers have a unique position within the NHS. In contrast to almost every other discipline in the service there is no code of conduct to judge their actions against."

Although Dixon (1991), former director of the Institute of Health Service Management, said

> "..that although the conduct issue had been discussed frequently it was dismissed as "inappropriate"."

An all party select committee of M.P.'s however felt that managers should also be held accountable for their mistakes (HMSO, 1990).

6.5. Clinical Freedom and Resource Constraints.

One issue is the question of the effect or possible effect that limited resources might have on clinical freedom. The consultant has the discretion to make

decisions about patients now under treatment without those decisions being reviewed or overturned by anyone else, even someone from the same discipline. What is done can be shared in a peer review context, where it can be discussed, but it is voluntary, no one can insist on knowing why something was done nor can they change it.

Clinical freedom has to do with treatment of patients, it does not affect management work. It is also concerned with current patients being treated; there is no clinical freedom to make decisions about future patients. Those are planning decisions. It is the issue of resources through contracts which seems to be the major fear for clinical freedom.

6.7. Summary and Conclusions.

The key question is how much independence should professionals, in this case specifically doctors, have when in theory and practice they are employed within an organization. From the discussion outlined there is almost no general answer. It appears however that where the work assumptions of the professional group in certain situations demand independent practice, as appears to be the case with doctors involved in clinical work, that this is inconsistent with managerial hierarchy or technical direction, although co-ordinating and monitoring relationships are feasible.

But in the words of Rowbottom (1978);

> "Over and above this they offer definite statements about the conditions under which any professional may be assimilated into bureaucratic organization, and the specific circumstances in which radically different organizational arrangements become necessary."

One difficult issue in the NHS is that of the development of an adequate managerial structure. There has been a desire to establish a unified managerial structure, neatly and tidily organized under a single unit manager or Chief Executive Officer. But for the reasons outlined this has not proved possible or satisfactory. It has been rejected because consultants, it is claimed, cannot be managed. It is not organizationally possible to place a Chief Executive Officer in a position of managerial accountability to consultants and retain clinical autonomy as the foundation of personalized services for patients. It is not possible to do so even if the Chief Executive is himself a doctor.

Another possibility, according to Jaques (1978), was to separate doctors from the rest of the services;

> "A role might then be established which would carry co-ordinative authority only in relation to the doctors, but managerial authority with respect to the other services.
>
> This concept, however, also proved unacceptable since it was found to run counter to the professional independence required in a wide range of medical services including for example, nursing, community

> medicine, medical administration, many paramedical services, and the administrative services."

The questions which arise are, who should be the leader of the team, and who in the final analysis should be responsible if anything goes seriously wrong? Who should be concerned with the investigations, diagnosis and treatment and who should be responsible for a prognosis. It is these questions which reflect the lack of provision for explicit allocation of primacy or of prime responsibility to professions other than medicine. For if primacy or if prime responsibility could be specifically allocated to one or other member of a team, then the uncertainty concerning leadership and final responsibility would not arise. When things go wrong individual accountability can all too easily be lost or hidden in a group.

Part 3. Development of Schema

CHAPTER 7

VALIDITY AND BIAS

7.0. Introduction to Validity

This study is based on participant comprehension or ethnomethodology, a research methodology which moves towards the break down of the traditional distinction between the role of the researcher and the subject. This is succinctly described by Heron (1989). In the old paradigm, only the researchers do the thinking that generates ideas, designs the project, manages the research and draws conclusions. The subjects often know nothing of what the researchers are thinking, and are involved only in the action and experience of the research. The more the methodology moves into the new paradigm the more this separation of roles is dissolved. Those doing the research as co-researchers are also involved as co-subjects. The same persons devise, manage and draw conclusions from the research and also undergo the experiences and perform the actions that are being researched. In effect you are involving more than one brain on the topic, which generates more ideas and designs, assists with the conclusions and which in turn helps to avoid researcher bias. Often the local knowledge provided by the researched may prove valuable in explaining certain actions and events. The extent to

which I have moved into this new paradigm is discussed fully in the next two chapters.

Having read some works on methods of Social Science research, I was concerned over the problems of bias and validity. One striking, but not surprising, feature and discovery is that the same issue is seen as different by differing people and differing groups. Doctors and managers, as we shall see in later chapters, see problems in their own particular world not only as different, but as separate. Indeed it has been suggested that problems are not organizations' problems but people's problems. As Sims (1987) states, problems are not "things" with some external provable existence but constructions or definitions made by us to make sense of our world.

This leads on to the validity of the research and the methods used. I was anxious to make use of the value of, a detailed investigation of, a few participants, rather than the responses to a questionnaire of many. The project involved in-depth interviews with 118 participants which were recorded and transcribed, with an additional 10 interviews not recorded as they took place informally over lunch. However, all the interviews had post interview impressions recorded by me together with brief notes.

The questionnaire type of investigation, although usually involving a larger group of respondents, means each has only a relatively short time to provide information. Not only is there less time for each answer, this answer tends to be an instant or automatic response. There is little time for considered reflection. The answer does not allow discussion around the topic. The range of responses is often limited to those decided by the researcher in advance. The detailed collaborative investigation allows for an in depth answer, probing of the responses, talking around and about the subject, discussion and clarification of issues and pursuit of related topics which may be relevant to the original question.

The first response given to a question may be only the initial response, given without perhaps the opportunity for considered thought. The response may be influenced by the person asking the question. The answer may be something which the interviewee thinks is helpful, or something the researcher wants to hear. The answer may be that which is most likely to bring the interview to a rapid close without seeming rude. Indeed the whole thing is a tangled mass of various influences and prejudices that have to be taken into account. I was anxious to avoid "simple answers" but to initiate a thinking aloud by the participants and I therefore moved from an initial rigid series of questions similar and related, for both

doctors and managers. The initial interviews considered the questions under three headings:

1. Whether they perceived themselves as a manager. Then why, and the preparation (if any) for this.

2. The management role. Asking questions about the details of what the subject actually did in this managerial role.

3. The management relationships. The concept of it, its development and the changes ahead.

Initially the interviews were kept tightly within these boundaries but I later moved to a more freely structured interview, allowing the participants to develop ideas in whatever direction they felt appropriate. This often resulted in a discussion leading to some general questions. For example the question of clinical freedom, consultant power and influence, the changes that are occurring, and coping with these changes. These changes later developed into the method described under 1.7.4.2. on Details of Data Collection in Chapter 1.

7.1. Some Approaches to Validity

In orthodox research the approach is primarily about methods. One approach to validity relates to the idea of

measurement, that is to say, a valid measure is one which measures what it claims to measure. A second approach to validity relates to experimentation (Campbell and Stanley, 1966). Here it relates to what is sometimes called internal validity, that is to say, did the treatment make a difference in this experiment? And external validity, that is to say, to what groups can this effect be generalised to include?

Reason and Rowan (1981:240) however feel there is another way of looking at validity, which is to think not only about the different sorts of validity, such as internal and external as referred to above, but also whether it looks right to a knowledgeable observer, so called "Face Validity"; whether a number of different views point in the same direction, so called "Convergent Validity"; whether measurements of different things come up with a difference - "Discriminant Validity"; whether observables can be seen "in terms of" more than "ideas" - "Construct Validity"; and (Diesing, 1972:203-224) how data fits within the whole picture - "Contextual Validity".

But Reason and Rowan (1981) also stress the need to be more involved with people, and they state that "We have to start looking at our notion of truth "to get away from the subject-object split". Schwartz and Ogilvy (1979:53) argue that it is possible to move away from the notion of

objectivity and subjectivity by developing the notion of perspective. This is defined as "a personal view from some distance" and "suggests neither the universality of objectivity nor the personal bias of subjectivity".

Reason and Rowan (1981:242) also state that we should move away from the idea that there is one truth and that there is some simple continuum between error and truth;

> "Certainly there are many ways of being wrong. (ignorance, illusion, collusion, delusion, hallucination, lies...) and also as many ways of being right".

The issue for me in practical terms was how to address the issues of making the research credible to others, dependable for myself and others, and confirmable should anyone attempt to do so. The most important for me was how could I establish confidence in the truth of my findings, and whether my research could be repeated with the same findings and to what degree the findings were the characteristics of the participants and the context and not derived from the bias, motivation, interest and the perspective of me the investigator.

The traditional view seemed to be that the findings would be worth taking account of if one could establish the truth of the findings, i.e. the internal validity, and secondly if one is able to show to what extent the findings were applicable to other participants, i.e. the

external validity. The traditional view also talks about reliability, that is to say, how one can be sure that if the inquiry were repeated with the same or similar subjects or respondents in the same or similar context the findings would be the same. According to Ford (1975:324) it must be reasonable

> "to assume that each repetition of the application of the same, or supposedly equivalent, instruments to the same units will yield similar measurements."

However according to Reason and Rowan (1981)

> "Reliability is not prized for its own sake but as a precondition for validity."

And finally the traditional view is that objectivity is important. How can one establish that the reasons, and to what degree the findings, are those of participants and not from the biases, motivations, interests or perspectives of the inquirer. Lincoln and Guba (1985:293);

> "Objectivity is threatened then by using imperfect methodologies that make it possible for inquirer values to refract the "natural" data-putting questions not directly to "Nature Itself" but through an intervening medium that "bends" the response; by engaging in inquiry with an openly ideological purpose; or relying on the data provided by a single observer."

In considering the treatment of this problem Guba (1981) proposes certain techniques, the chief of which are prolonged engagement and persistent observation,

triangulation, peer debriefing, negative case analysis and member checking.

Reason and Rowan (1981) feel that conventional criteria are inappropriate for post positivistic research. But if so what should replace them? According to Lincoln and Guba (1985:295) the solution includes truth value or credibility. (cf internal validity);

> "When naive realism is replaced by the assumption of multiple constructed realities, there is no ultimate benchmark to which one can turn for justification- whether in principle or by a technical adjustment via the falsification principle. "Reality" is now a multiple set of mental constructions."

It is therefore necessary to show that both the findings and interpretations that are also reconstructions are credible to the builders of the original multiple mental constructions. Secondly there is applicability or transferability. (cf external validity);

> "It is in summary *not* the naturalist's task to provide an *index* of transferability; it *is* his or her responsibility to provide the *data base* that makes transferability judgements possible on the part of potential appliers."

Thirdly there needs to be consistency or dependability. (cf reliability). A major technique being the confirmatory audit (Halpern 1983) where raw data including field notes, data reduction and analysis, condensed notes, summaries, theoretical notes, working

hypotheses, concepts and hunches, data construction, findings, conclusions, interpretations and inferences, final report, connections to existing literature and integration of concepts, relationships and interpretations, process notes etc. are subject to a "confirmability audit".

Lastly there is neutrality or confirmability. (cf objectivity). Described by Scriven (1971:95-96) there is a reference to the *quality* of the testimony or the report or the (putative) evidence, and so I call this the "qualitative sense". Here, "subjective" means unreliable, biased or probably biased, a matter of opinion, and "objective" means reliable, factual, confirmable or confirmed, and so forth. It removes the emphasis from the investigator onto the data itself. The issue is no longer the characteristics of the investigator but of the data: are they confirmable or not?

7.2.0. Some Practical Aspects of Validation.

Reason and Rowan (1981:249) feel that it is important, instead of a single cycle of data collection, for there to be multiple cycles, where the theories and concepts are progressively extended, refined, differentiated and integrated reaching towards a theoretical saturation.

7.2.1. The First Validation.

Immediately after an interview was completed I either wrote or dictated an impression of the main points which were left in my head. I worried that this might generally be the last, or one of the last topics discussed, but this proved not to be. Within days (though later in the case of the US hospitals) a transcription of the whole interview was produced.

The notes of the interview, the post interview notes or transcription and the main interview transcript were then reviewed for the main ideas and a summary of about two A4 sheets produced. This was sent to the participants with a letter, thanking them for their help, assistance and time and inviting them to correct any errors of substance, understanding or change of view.

Every participant in the U.K. except one agreed to this and returned the paperwork. The participant in question had already indicated that she would not do so, stating that she stood by what she said on the tape, the meaning of what she said was clear and she would not wish to change anything.

The returned information was often heavily amended, changing the emphasis and occasionally the meaning. One

participant rewrote and retyped the whole of the two sheets.

From the U.S. only about half the letters were returned. This may have been partly because of poor postal services as the returns did increase when faxed.

7.2.2. The Second Validation.

Any queries from this first cycle could then be answered by a second letter, fax or telephone call. I used this on a few occasions to deal with specific queries which became apparent later as my knowledge increased.

7.2.3. The Third Validation.

The third validation or cycle was carried out by second interviews. In view of the large number of first interviews it was not possible to interview everyone again, especially in the U.S. hospitals as I had failed to secure any funding for this. My aim was to concentrate on those who had revealed most knowledge, enthusiasm and willingness to participate; even though this might be give a bias, I judged that continuing to interview unwilling, negative participants was unlikely to provide me with any more information than I already had from them.

7.2.4. The Fourth Validation.

It was only when this saturation point referred to above in section 7.2.0. had been reached with the Clinical Directors that I felt able to move on to the next stage of interviewing participants outside districts but who had regional or national roles, and the academics in the field. With these interviews I used exactly the same validation methods described above, with the cycle of correspondence etc.

7.2.5. The Fifth Validation.

The fifth validation cycle was to involve participants in workshops and group meetings. Some of these were on a informal basis but a number were formally set up as feedback sessions with both clinical directors and managers present, the final one being a group of ten pairs of each. Here a range of finalised issues concerning relationships and authority surrounding the two groups was discussed openly.

7.3. Some Problems of Bias.

Entering a research project of this nature I recognized that I had preconceived notions, existing experiences and prejudices. We are all influenced by our background, our training, our reading and our work. Unless it were possible to bring in a "man from Mars" Enthoven (1985:5) who had no prior knowledge of anything to do with our culture and experience it would be difficult to exclude bias. Even the "man from Mars" could be biased as he might favour the way one group works, looks or behaves. The more I investigated all these issues the more I realized that one could become seduced by the issues themselves and as this was not to be a thesis into social science methodology but had to remain firmly practical, I had to look for the practical solution which seems to be based on awareness. I took recourse in Reason and Rowan (1981:304);

> "Awareness is, however, a great step towards prevention."

So although bias is inevitable, it can be recognised and acknowledged, and this is a step towards resolving the difficulty that it introduces.

7.4. Researcher and Participant Biases.

Researcher Bias	Participant Bias
The Bilateral Biases	
Personality Bias	Personality Bias
Perceptual Bias	Perceptual Bias
Cultural Bias	Cultural Bias
Class Bias	Class Bias
The Unilateral Biases	
Solitary Bias	Conversational Bias
Ethical Bias	Documentary Bias
Experimenter Bias	Perspective Bias
Observer Bias	
(Self) Observational Bias	
Theory Bias	

It seemed to me that there were likely to be a number of biases and these could be considered under a group of headings. I put them into three categories, those that were particular to the researcher, those affecting the participants or subjects of the research, and a group which affected both but which might need to be considered separately for both researcher and participant. To a certain degree they all link and may merge into one another.

7.5.0. The Bilateral Biases

The problems of researcher bias and of participant bias are similar in one respect. In both cases, bias results in a partial or one-sided account of the subject being studied. But whereas researcher bias could be checked and corrected by using another researcher with a different bias, this is hardly possible with participant bias. It is extremely unlikely that two researchers will investigate with the same participants simultaneously. It might be possible to cross-check and combine research on similar participants, but there would still be a problem determining which participants were similar enough in all respects. Mannheim's suggested solution (1936:95) is that when a bias cannot be checked against the output of a different bias or perspective, it can be checked for its compatability with the subject being studied.

7.5.1. Researcher and Participant Personality Bias

Personality biases can be located, interpreted, and to a degree allowed for on the basis of awareness and knowledge. This came with greater involvement and experience as the project progressed. I identified the sterotypical macho manager and the arrogant consultant attitude.

What was more difficult to evaluate was the effect of my personality particularly on the interviews. Even my initial approach may have had some effect on the resulting responses. Initial impressions are often important and may take time to change. Two or three participants told me later in the interviews things they said they would not have told me earlier and sometimes they even changed their views as a rapport was established. A manager said;

> "Well I can tell you this now I feel I know you, that I certainly would not have done in the first few minutes."

And a Clinical Director explained;

> "I feel I can tell you things now, an hour ago I would not have even considered saying and change things that I might have said previously. I feel that I can trust you now."

So to some degree the achievement of greater self knowledge and self awareness is an important part of training for, and outcome of the project.

7.5.2. Researcher and Participant Perceptual Bias.

Perceptual and cognitive distortions may occur in material in which the informant is personally involved. Important details may be missing in material or information in which they are not immediately involved,

and so on; the writing of Vidich and Bensmans (1960) and Llewellyn and Hoebel (1941:29-37) considers this.

This means that statements cannot necessarily be accepted as truth, but have to be checked against other evidence where possible. The purpose of this cross checking is not just to find the true and dependable subjects and to discard the rest, as there might then be little material left, but rather to estimate the probable direction and amount of bias and to interpret the information accordingly.

The pattern of this bias itself can be of interest. The particular pattern of distortions can help to locate a participant relative to other subjects. If other evidence indicates that a particular report is idealized, the pattern of idealization and the relation between ideal and actual reveals something about the institution.

Stories and descriptions of events by one group about another can be interpreted as a statements revealing the teller's fears and hostilities. In short, the statements of a participant cannot be treated as totally objective descriptions of a subject by an outsider, but rather as part of the subject being studied.

Hypotheses or interpretations derived from direct observation and the statements of a subject can be tested

by asking a subject's opinions about them. According to Diesing (1972:153) in a conversation he reports with Needham;

> "for some British ethnologists this is said to be the ultimate test of an interpretation, and nothing that fails this test is acceptable, no matter how strong the other evidence for it may be."

7.5.3. Researcher and Participant Cultural Bias

The problem of cultural bias is also a difficult one. Within the UK it relates to cultural differences between doctors and managers, but between the UK and USA there are additional cultural factors. As a member of the medical profession I know that there is a stereotype view that we regard managers in hospital as inferior. This is an issue that I address in the chapter on doctors and the chapter on managers and their views. It is also discussed in the latter chapters.

Diesing (1972:323) feels that to some extent the social sciences can be said to have transcended the ethnocentric predicament by their extensive traditions of cross-cultural research, though cross-cultural sensitivity is still inadequately diffused. In addition he sees the beginnings of a partly autonomous culture of science, drawing its members from all over the world and thus incorporating elements from a variety of cultures. But he feels that;

> "The above suggestions will not impress those philosophers who deny the existence of uncontrollable bias in themselves. They may admit that some people are irrational, but their recommended solution is likely to be that of Russell; Be more rational, like me. For these philosophers the foregoing remarks serve only as a partial rationalization for my choice of the method used in this book. I have hoped, by joining the cooperative, empirically controlled enterprise of science, to subject my own biases to some measure of eventual control."

7.5.4. Class bias.

The problem of class bias, although difficult to deal with, I felt was not a major problem in this study. Mannheim (1936) discusses it at length with the suggestion that

> "insofar as social scientists are drawn from different classes and insofar as they can achieve a partial autonomy from their class background and a tolerant appreciation of other viewpoints, the various class-bound viewpoints can supplement and counteract one another somewhat."

For me the question was not one of class origin but of experience within the field of activities that I was investigating. The question seemed immaterial as I was an insider to the acute care hospital environment. The fact to which some participants referred that managers and doctors attended different schools or universities, or in the case of managers, had not had a university education was recognized however, as was the fact remarked upon more than once that managers and doctors belonged to

different golf clubs. This issue has parallels with cultural bias.

Having recognized this rather than ignored it, I addressed it as an issue and have discussed it in the sections on data and conclusions.

7.6.0. The Researcher Biases

The problem of researcher bias is that in which the presence of the researcher changes the subject studied. Researcher bias occurs throughout the social sciences but is important in clinical and field methods. Every investigator must perceive and interpret the subject matter from some standpoint and thereby bias the conclusions. Also every scientist must be active within the subject matter in some fashion and must therefore change it as it is studied. Even the act of singling people out for investigation has an effect on them.

7.6.1. Solitary Bias

I was researching this as an individual and not part of a multi-disciplinary team. Apart from recognising that as an issue this was difficult to overcome, I did consider it was useful to arrange for some of the interviews with both managers and doctors to be carried out by a third person, not involved in writing, although this did not

resolve the possible problem of the writing up, conclusions and suggestions being carried out by one individual. I have tried to balance the problem by taking account of and arguing the case as given me by other professional groups, attending meetings and conferences organised by the Institute of Health Service Managers and the Royal College of Nursing, on topics relevant to the study, but particularly by discussing these issues openly in multi-professional groups of doctors and managers. I have organized workshops to include members of other professional groups to discuss together and obtain feedback on all the issues raised. The study being largely iterative and enfolded, the view that emerges is not that of a solitary author but the collective views and judgement of many individuals, from many disciplines, varied professional experiences and backgrounds.

7.6.2. Ethical Bias

A closely related ethical problem is that of the researcher's indebtedness to his participants for the knowledge he obtains by studying them. The subjects take time to talk to the researcher, they befriend him, make a place in their lives for him, concern themselves with his work and seek out ways to be helpful. What can the researchers do for them in return? Gusfield (1960:106)

expresses the researcher's feeling of indebtedness nicely:

> "The WCTU was my bread and butter....They had been pretty helpful to me in many ways, and I was using them. This kind of situation is bound to fill the field worker with ethical misgivings, and I had a sincere feeling that they deserved some kind of repayment."

Indebtedness may not be such a problem in experimental work where subjects are paid by the hour for their participation, and this is considered to be a sufficient discharge of the experimenter's obligations. One might expect it to be a problem for other researchers, who ask their subjects to take up to several hours to fill out questionnaires, take tests, or give interviews; however Diesing (1972) says:

> "I have never come across any expressed recognition of this problem, either oral or written."

He says that field workers, in contrast, frequently express awareness of the problem. Perhaps the difference is because of the participant observer's more personal involvement with his subject, which contrasts sharply with the tester's or questionnaire writer's impersonality. Or perhaps the greater contribution of the field worker's subjects produces a greater actual indebtedness. Several solutions have been devised for this problem (Wax 1960);

> "Probably the most important form of repayment is the continual small courtesies of the field worker; he should be a good listener, express genuine respect or deference in attitude, perform small favours, participate seriously in ceremonies if asked."

But no matter what form of repayment is found, there must always be a residual indebtedness inherent in the diffuse relationship that the field worker develops with his subject. In a specific, quasi-contractual relationship, indebtedness is also specific and can be completely discharged by a specific payment, but in a diffuse interpersonal relationship, indebtedness is diffuse on both sides and can never be definitely eliminated. The result is a lingering sense of debt and guilt on the part of the field worker. This may express itself in over-indentification with the subject, a reinforcement of the identification and involvement that normally results from participant observation (Gans 1967:444) and (Miller 1952:97-99).

7.6.3. Experimenter Bias

The experimenter appears to try solving the problem of objectivity by detaching himself from his experiment and his subject matter as fully as possible, emotionally and physically. In this way he hopes that experimenter bias will have a minimal effect on the results. It might be argued that this is also the proper solution for the participant observer; although he cannot be as detached

and objective as the experimenter, he should still try to imitate him by remaining detached and passive where possible.

7.6.4. Observer Bias

The problem of observer bias occurs when observation reports are distorted and mistaken. Redfield has suggested a solution to this (1960:132-137) cf also (Myrdal 1944); he proposes that the same case be studied by two or more investigators with different biases, so that each can reveal and correct the exaggerations and omissions of the other. Objectivity is approached by combining the accounts and by rechecking where there is direct disagreement, the sign of falsehood being either direct contradiction or the incompatibility of the different accounts.

7.6.5. (Self) Observational Bias

Self-observation is a special source of evidence sometimes overlooked. When an observer has been well socialized, or when a clinician has established a substantial relationship to a patient, his own reactions become part of the system he is studying. Consciously and intellectually he is still the detached observer, but emotionally and subconsciously he has become part of the subject matter. Diesing (1972:151);

"Personal observation is a most important kind of evidence, chiefly because it is cheap and readily obtainable.....The main problem with observation is observer bias."

7.6.6. Theory Bias

All the theories and hypotheses the observer takes into the field affect his perception and interpretation. Theoretical biases can be isolated by having one's theories made explicit to oneself, and by consciously searching for evidence that contradicts one's own theories and hypotheses (although I doubt whether anyone is truly able to do this). And most important, observations need to be checked against other kinds of evidence.

Nevertheless it seems to me that this other evidence may be no more dependable than any other, and that informants' opinions are as much in need of interpretation and evaluation as any other bit of information. An informant may agree with an interpretation because he wants to be agreeable, or because he is not interested in the topic and does not want to be involved in an argument about it, or because he is momentarily persuaded by the eloquence or the status of the participant observer. He may disagree and correct an interpretation because he wants to show the researcher that the latter is still an outsider who does

not understand, or because the style of theorizing is unfamiliar or disagreeable to him, or because he wishes to protect esoteric knowledge.

Consequently it is necessary to evaluate the opinion in terms of the relationship to the observer, the style of thought and expression, and the interest and involvement in the subject being discussed. If all of these factors are just right, the informant becomes a kind of collaborator and his opinions are most valuable, but this does not happen often. Here also we see one of the links between various biases, in this case between theory bias, perceptual bias and conversational bias, and possibly other links.

7.7.0. The Participant Biases

Nor are the biases solely related to the researcher. The participants may knowingly or unwittingly cause bias.

7.7.1. Conversational Bias

Interviewee statements may be biased in various ways, depending on the topic, the circumstance, the interviewee, or the relationship to the researcher. To a stranger a participant is likely to give an idealized version of what happens or how he feels. A co-operative participant may say what he thinks the researcher wants

to hear or would find interesting. Esoteric material may be simplified to the researcher's presumed level of comprehension. The participant may relate official versions of events that have been read, or may summarize biased accounts read in papers or journals or may quote recent statements by biased friends and colleagues.

7.7.2. Documentary Bias

The same cautions that apply to participant perceptual bias and conversational bias apply to documents and written records. Unofficial memos and reports must be interpreted in their organizational context. Official records give only an idealized public version of what happened. Often the omissions are more interesting than the inclusions in such records, Dalton (1964:77-81). One Clinical Director recognized this when referring to records of hospital meetings;

> "Some people "wash the minutes" so you never detect there is any type of spirited discussion about anything and I am against that. I think the minutes ought to reflect everything, without mentioning individuals, but say there was a big fight over this, and the majority of people shouted down the speaker, and this is what is going on. Well, it is the only institutional memory of what happened."

7.7.3. Perspective Bias

The position of the individual and their mode of involvement can provide a bias of perspective. This does

not mean that observations need to be discarded as invalid, they simply need to be interpreted. Biases of perspective can be located, interpreted, explained, and allowed for on the basis of comparison with observations from different perspectives.

7.8. Creative Value of Bias

What I had read, and so far summarized, began to mount up evidence for suspecting that the whole project might be riddled with defects, but there is another side. Participant observation depends essentially on the creative use of bias to discover things that would otherwise not be observable, so the minimizing of bias and involvement could destroy the method. An observer not involved will be unable to empathize, to see things from the perspective of his participants, and may well miss much of the meaning of what is seen. As a result the wrong questions might be asked, (Ladd, 1957:xiv);

> "cf. the informant Bidaga's complaint: "I have been trying to explain these things to you for thirty years, but you never asked me the right questions."

And one might look in the wrong places. In addition, a too emotionally detached person might not be as readily accepted into confidential activities such as the Medical Executive and Management Board Meetings because the coldness and aloofness would disturb the atmosphere.

There are situations in which detachment might be welcomed, such as quarrels, and there are public situations in which the observer's attitude could be unimportant, but in personal contacts, detachment would seem a barrier.

Finally, an observer who does not actively probe and provoke may miss important aspects of his research, what the participants really consider as important to themselves, the defences the participants have against perceived threats, their reactions to crises and problems and so on.

7.9. Discussion

By now it is clear that the holist ideal of studying, and taking account of, all the important aspects of a particular human whole, is unattainable, and we must be satisfied with approximations, and the recognition of certain assumptions. The various solutions that people have devised may move in opposite directions, or may combine parts of both directions.

One direction is for the investigator deliberately to circumscribe a limited area of study, making his limits explicit and hoping that others will supplement his

efforts in other areas. This appears to be the line suggested by Gluckman and Devons (1964). They add that,

> "only the investigator should keep an open mind about whether the closed system he has set up is an appropriate one. As his investigation progresses he should be ready to shift boundaries to include important new factors in his system."

Diesing (1972) however feels that a bias is only misleading or inappropriate if it prevents the researcher from entering into the world of his subject and acting within that world;

> "When the researcher's actions and resources are inappropriate from the standpoint of the subject, when they produce confusion and misunderstanding, the researcher is acting on premises that are different from those of the subject. This always happens during the period of the researcher's socialization, but if confusion and misunderstanding persist they show that a persistent bias of the researcher which is unacceptable to the subject is preventing him from understanding the subject. Consequently the researcher can check the appropriateness of his biases to his subject by noting persistent difficulties of communication and rapport."

Such checking is, of course, easier to do if the researcher is aware of his biases and can take a somewhat detached attitude toward them. Fortunately the participant observer is more thoroughly and more continuously active than practitioners of other methods. He does not take the detached neutral position of the experimenter and the survey researcher, but actively involves himself in his research, emotionally, cognitively, and behaviourally.

He has to accept and work within the systems of the people he studies, and form genuine, not feigned attachments. Such a socialization process is transactional, with influences coming from the socialized as well as socializer. Beliefs may be selectively taken on and reinterpreted, and attachments may necessarily be selective if they are genuine. Diesing (1972:280):

> "In addition, the participant observer continually changes his subject matter as he works with it in his newly learned roles, and the changes necessarily reflect in part the contributions he has made to his own socialization."

Thus one could say that the participant observer not only perceives his subject matter from a bias, as all scientists do, but also that he remakes the subject matter in his own image as he studies it. Reason and Rowan (1981:246):

> "I know myself well enough, I know my bias as a researcher. Every researcher brings to the research his own biases, rigidities of character and these contribute to the perspective."

So this research was not conducted alone. There were colleagues, peers, mentors, friends, wife and children who could challenge and shock me out of habitual ways of thinking. To do this research one needed both people who could offer support, and those willing to challenge and confront.

An issue that concerned me was consensus collusion. Heron 1981:164) says;

> "However many persons agree in the research conclusions this is *per se* no guarantee of their validity. *Consensus gentium* is no adequate criterion of truth; it may simply represent widespread collusion to ignore crucial and relevant variables."

I countered this by inviting some of the co-researchers to take devil's advocate roles so that by confronting, challenging, disagreeing, picking holes, and so on, the inquiry process was successfully progressed. For example in a workshop I asked groups of Clinical Directors and Managers to take identify areas of new ideas, new connections and possible errors in the cognitive maps discussed later in the data section.

There is inevitably bias, not only from my background, my academic training and my personal experiences but in my choice of topic, my choice of methodology, my choice of participants. I do recognize these biases and in the end the results of the research do contain an element of my own view of the question asked, the answers given, the feedback and validations, the literature review supporting or denying my arguments etc., although I have tried to be as impartial as human nature allows. I have recognised that bias must creep in. This is an issue which I have addressed more fully in Chapters 9 and 19 on

my personal lessons and personal reflections and the learning curve of my experience with the project.

CHAPTER 8

METHODOLOGY

Theory and Choice of Research Methodology

8.0. Introduction

Lincoln and Guba (1985:15) describe three eras of research , prepositivistic, positivistic and postpositivistic The first was the longest and is the least relevant to this work. It is typified by passive observation. Later scientists began to try ideas to see if they worked and they became active observers and the positivistic era had begun. Not only did it influence hard science but also religion, politics, and even philosophy.

But there are challenges to positivism and much has been written but Lincoln and Guba (1985:24) summarize the following:

1. Positivism leads to inadequate conceptualization of what science is.

2. Positivism is unable to deal adequately with two crucial and interacting aspects of the theory-fact relationship.

3. Positivism is overly dependent on operationalism, which has itself been increasingly judged to be inadequate.

4. Positivism has at least two consequences that are both repugnant and unfounded: determinism and reductionism.

5. Positivism has produced research with human respondents that ignores humanness, a fact that has not only ethical, but also validity implications.

6. Positivism falls short of being able to deal with emergent conceptual/empirical formulations from a variety of fields.

7. Positivism rests upon at least five assumptions that are increasingly difficult to maintain:

Ontological assumption, that things can be broken apart and studied independently, and the sum is then the total of the parts.

Epistemological assumption, concerning the separation of the observer and the observed.

Problems of contextual and temporal independence, that what is true at one time and place may, under appropriate circumstances (such as sampling), also be true at another time and place.

Assumptions of linear causality.

Assumptions that the study is free from bias.

It is the result of some of these criticisms that investigators particularly in the social sciences have moved into the postpositivistic era, where the basics are almost the reverse of the characteristics of positivism. Data is not detachable from theory, theories are the way facts are seen, the language is less exact and meanings are determined by theory. So although much evidence has emerged of the value of postpositivism from the hard sciences, the arguments for its value is greater when human beings are studied.

Conventional inquiry is often labelled as positivistic and Lincoln and Guba (1985: preface) refer to "the difficulties it is currently encountering." Positivistic research is sometimes criticized for producing questionable results (Phillips, 1983), but Das (1983) has stated that the two approaches are not to be regarded as opposites but appropriate to different areas of interest;

> "Qualitative and quantitative methodologies are not antithetical or even alternative."

So a paradigm revolution has occurred. It is said that postpositivism is a new paradigm not reconcilable with the old, although there have been those who have suggested the time has come for a realignment. But equally there are those who regard compromise as no more possible than it could be between prepositivism and

positivism. Interestingly Gioia, Donnellon and Sims (1989) describe an example of a set of data analysed in both the positivist and postpositivist methods. They reviewed videotaped interviews and used a method of mapping the script and compared it with previous analysis done by coding the utterances. The results were not contradictory but the two methods saw different things.

8.1. Effect on this research project.

The key to the choice of methodology is the nature of the research question, and having read studies on management, organizational development, change in organizations and studies of human service organizations, I decided that the most appropriate method of investigation and the most useful and reliable results came from postpositivistic methods, sometimes called naturalistic. These studies do not seek to verify a theory but instead allow the theory to emerge from the data. Whenever the researcher imposes theory before the data is collected there is always a danger of moulding the facts to the theory.

8.2. Postpositivist Methodology

People do not behave like chemicals, nor do they behave simply in response to some stimulus; they construct a meaning to the stimulus and behave or react in a meaningful way. A simple organism may recoil at the heat

of a fire, but a man may run for water, to ring the fire brigade or into the building to rescue someone calling for help. Humans act towards things on the basis of the meaning that the things have for them.

The meaning that certain events have for individuals is itself the product of experience and interaction within society. The person seeing the fire may do none of the above and be rooted to the spot in terror because of a childhood experience. The meanings of events, situations, things and experiences are all affected by previous knowledge, experiences and knowledge about others' experiences.

The role of the researcher may be affected by the researched's behaviour, or by the feelings of the researched to the researcher or by previous research etc. The person seeing the fire rushes into the building to rescue the child of a hysterical mother, but may act with more coolness and calculation if in the company of a person who has experienced such a disaster. Thirdly, meanings may be modified and handled by a process which causes different interpretations to be ascribed to words, actions and behaviour. Anyone observing these reactions of the person described above and observing in a purely "positivistic" way might place any interpretation on what he had observed and build up a case to support that. For

my research I needed to know what the researched thought and felt and why they did what they did.

Human beings are therefore initiators of action and not just responders. All these influences need to be taken into account. The research methodology has therefore to be appropriate to such a perspective. Such a method is not that of positivism with its emphasis on statistical data, averages and theory requiring proof.

In the words of Kant (1969);

> "Perception without conception is blind; conception without perception is empty."

Thus to avoid the emptiness it is necessary to participate with the researched while observing them or to spend a considerable amount of time talking to them in a relatively unstructured way about their perceptions and actions.

Various names have been given to the new paradigm largely because the people who practice it take differing views on what it implies: naturalistic, postpositivistic, ethnographic, phenomenological, subjective, case study, qualitative, hereneutic, humanistic, new paradigm. Terms from the whole range merge into one another and are not entirely distinct. Authorities on each method, hold views that theirs is the right way to do it. Basically

there are the ethnomologists, the structuralists and those in the middle.

Neither can Naturalism be defined in simple terms. In fact Guba (1978) has cited nine differentdefinitions of naturalism. What I regard as most important however, are two factors: That the researcher does not manipulate or influence the researched, and that the researcher sets no theory on the outcome before analysis of the data. With the new inquiry there are five basic axioms. Lincoln (1985);

Axiom 1. The nature of reality or ontology which the Oxford English Dictionary describes as a study of the nature of being. In the positivistic theory reality can be fragmented into independent process and variables which can be studied independently whereas in the naturalistic version the realities can only be studied holistically.

Axiom 2. Considers the relationship of the knower to known and is referred to as epistemology. The Oxford English Dictionary describes this as the theory of the method or grounds of knowledge. It means in effect that the researcher and the subject of the inquiry interact and influence each other.

Axiom 3. Concerns the possibility of generalization. Naturalistic inquiry does not develop a body of knowledge in the form of a law, theory or hypothesis that holds true anywhere and anytime, but rather "seeks to form" a working hypothesis to describe an individual case.

Axiom 4. On the possibility of causal linkages positivism explains every action as the result of a cause either preceding that effect or occurring simultaneously with it. Whereas the naturalistic version is that all things are in a state of mutual movement and development, and it is impossible to distinguish cause from effect.

Axiom 5. Discusses axiology or the theory of value. Positivistic inquiry is value free, whereas naturalistic inquiry is not and for the following reasons. The inquiry is influenced by: the researcher's values, in the choice of inquiry, boundaries and focus of the research; the choice of method of carrying out the investigation; the choice and method of data collection; the analysis of the data and the interpretation of the results.

8.3.0. Various Postpositivistic Methodologies

Having reviewed the arguments for the appropriateness of postpositivistic methods I will now summarize the well documented arguments about the value of the various detailed techniques, beginning with the more conservative approach and working further into the postpositivistic methodologies. In particular I will consider the method and problems which occur in the practical application of various studies, commenting on the appropriateness to this project, the problems of analysis, and issues of validity. Lastly a set of criteria and the reasons will be set out for the choice of method.

8.3.1. The Constant Comparative Method. Grounded Theory.

The constant comparative method (Glaser and Straus 1967) (Glaser 1978) for grounded theory building, is concerned that any new emerging theory is strangled by preconceived ideas on the part of the researcher. They collected data by interview and observation, which were coded sentence by sentence into categories which had certain properties. Ideas that linked the properties and categories were noted and the whole eventually linked to form a theory.

Concepts and properties could also come from relevant academic literature as this was regarded as relevant data but could not come exclusively from this source. The new

ideas would then emerge from what people do and say. The process continued until a saturation point was reached and the result is a theory fitted and worked for that setting.

Relevance for my research

The amount of data was likely to be overwhelming and the difficulties in implementing the technique are discussed by Miles (1979). It is said that the researcher pays more attention to biases and it sensitizes one to the data in more depth. The main drawback I felt was the amount of data likely to be collected and the sheer volume of work in processing it. It seemed likely to generate ideas, but it really seemed most appropriate in a situation where there was rather limited data and as much information as possible had to be squeezed from it.

I liked the idea of using evidence available from academic literature in addition to fieldwork of observation and interviews. This method appeared to make no particular reference to the problems of the relationship between researcher and subjects, which is one of the axioms of the postpositivistic methods.

8.3.2. Unobtrusive or Participant Observation Method

The participant observation method, (Bogdan and Taylor 1975) and (Taylor and Bogdan 1984) is careful observation by the researcher, present in the setting for a period of time, and who interacts with the subjects of the research and who unobtrusively and systematically collects data. The researcher has no personal stake in the setting but is supposed to empathize with the subjects. According to Diesing (1972:291);

> "The participant observer tests the adequacy of his account by seeing whether its various parts are acceptable and intelligible to the people he is working with, though not necessarily identical to their own verbal formulations. He does this not by asking their approval of an article - which tests mainly friendship and politeness - but in informal discussion continued over a period of time. Or, expressed somewhat differently, he tests the adequacy of his understanding by acting on it and seeing where his actions are unintelligible or puzzling to others."

Participant observer methods appear to have been first developed by anthropologists, though they are frequently used by sociologists, social psychologists, political scientists, and organization theorists. They are useful for studying a formal organization or institution, the emphasis being on the individuality or uniqueness of the system, its wholeness or boundedness, and the ways it maintains its individuality. Diesing (1972:5);

> "The primary objective is to describe the individual in its individuality, as a system of rules, goals, values, techniques, defense or boundary-maintaining mechanisms,

exchange or boundary crossing mechanisms, socialization procedures, and decision procedures."

Relevance for my research

Although this fitted the careful observation I planned to make within my own hospital environment and considered the relationship between researcher and subjects, I felt initially it had little overall value as a scheme as I did have a personal stake in the setting and I felt the method had little to offer the criteria I was seeking. As the study moved on and I expanded the boundaries outside my own hospital I was drawn more towards this method.

8.3.3. Participant Comprehension Method. Ethnomethodology

Disciplined abstractions from intimate familiarity were described by Lofland (1976) who wrote what was a guide for participant comprehension. The researcher had to develop an "intimate familiarity" with the setting. The need to be close to the data is obvious, and the problem of bias inherent in unobtrusive observation disappears when the researcher becomes too close to the setting, while the results of pure observation may be meaningless speculation. Mangham (1978) says "the way to avoid emptiness and stimulate groundedness is to be intimately familiar with one's subject matter, to have a detailed and dense awareness of a particular set of social actors

over a period of time and to seek to understand how it is that they go about defining and acting in their particular social world, to participate with them while observing ...their perceptions and actions." Again Lofland (1976) also regretted the lack of "intimate familiarity" in studies to date, but pointed out the difficulties often involved in entering settings together with difficulties in analysis. The presence of the researcher also has to make sense for the subjects. This is tackled in Action Research in which the researcher sets a real and relevant task for the people in the setting. (Rapoport, 1970. Susman and Evered, 1978 and Sanford, 1981). Lofland (1976) also states his ideas on how explanations can be developed from data.

Relevance for my research

Here were some really useful concepts. I was already intimately familiar with the setting, close to the data and could plan to undertake a real and relevant task for the people in the setting; I would be a student of ideas and not just a participant.

8.3.4. Endogenous Research

Maruyama (1978) went even further in the idea of the researcher becoming intimately familiar with the setting. He works with the subjects and they become co-

researchers. They decide the relevant research question for themselves, design the plan and even undertake the research. The role of the researcher is to help with this endogenous research.

Relevance for my research

Unfortunately it is a method appropriate only to certain situations. Reference has been made elsewhere to the difficulty of entry to studies of medical work and of doctors and there is no way that this sort of time commitment could or would be given by the subjects of this research, even to a colleague.

8.3.5. Cooperative Inquiry

The new paradigm of research involving cooperative inquiry is explored in collected papers on naturalistic methods by Reason and Rowan (1981). These go beyond participant observation and ethnomethodology to the form of inquiry which includes the subjects as co-researchers. They feel that the grounded theory approach is "firmly within the old paradigm". They feel that the researcher's own learning and interactions are the essence of the experience and the research. The knowledge is characterised as:

propositional knowledge or facts,

practical knowledge or skills,

> experiential knowledge which is " knowing an entity- person, place, thing, process, etc - in direct face to face encounter and interaction." (Heron 1981).

There is similarity with endogenous research. They also acknowledge the criticism of the researcher needing to know him or herself (through co-counselling for example) which makes him or her seem like a person on a higher plane, specially aware and "pure" enough to do the research. They counter this by saying, "We cannot study human processes except as aware human beings..."

Relevance for my research

Again while the idea of cooperative inquiry is appealing it would require what the subjects would regard as an unreasonable amount of time. It also involves the possible danger of personally damaging feedback in a setting in which I would continue to work after the study had been completed. Also there was the possibility that some of the information fed back might offend the principle of confidentiality which I had promised to all the participants.

8.4. Criteria for this project.

Having been trained in the positivistic methodology, even as someone who had some reservations and doubts about it

in certain circumstances, I had to balance my initial scepticisms for postpositivist methods against the obvious need to use a form of naturalist inquiry for this research. I was also keen to involve the subjects of the research, but within the limitations of time they would be prepared to give the project. There was in addition the danger I wished to avoid of setting off a chain of consequences after the study was completed while I continued to work there. Clearly there had to be limits to the sharing of knowledge and therefore the involvement of the subjects as co-researchers, although I feel very sympathetic to the idea and which would clearly produce good results. I also felt the need to keep a tight control of the direction of the research whilst remaining open to contributions to enhance my understanding.

8.5. Analysis of Naturalistic Data

My biggest worry after clarifying the details of what data to collect, was that of analysis of the data, especially as it would obviously be a considerable amount. The complexity and difficult thinking that goes into analysing naturalistic data has been well described by Marshall (1981). Allowing ideas to develop has been set out by Daft (1983) who likens the research to story telling as a poem rather than as a novel. He points out that research decisions are not linear and advises relating ideas to common sense and to learning about

organizations at first hand. This is similar to Morgan's (1983) advice to engage with the data and treat the research as conversation.

My early anxieties about the volume of data were not allayed or dispelled by my reading; indeed the more I read the more it seemed likely to be a problem. However my hope was that previous researchers were on the right lines, and their experience and results were a reassurance in the early days of the project. I later found the amount of data useful in looking for concepts and evidence to support or refute ideas.

8.6.0. Dilemmas in qualitative research

From the start having read some works on Naturalistic Inquiry I was particularly concerned about the problem of bias and validity discussed in the previous Chapter. One of the striking, but not surprising, features and discoveries is that the same issue is seen as different by different people and different groups. Doctors and managers see problems in their own particular world as different.

8.6.1. Validity of accounts

If the participants are part of the research and gaining something from it, they are more likely to tell the

truth. On the other hand because of my lasting involvement and working relationships in the hospital setting, I could conceive of situations where the accounts may be less than truthful. I felt however that my familiarity with the environment would enable me to identify this.

8.7.2. The researcher as expert

There is also the relationship caused by the differing expertise of the researcher and co-researchers or research participants. Initially I felt unsure whether this would cause problems, in that although the people involved are treated as co-researchers they may feel and behave like research subjects. This was something of a problem as I was sometimes asked for my opinion on issues that I was researching, but more often my opinion was dismissed as based on "unscientific methods". This was particularly likely to occur when the participants had an academic background which is positivistic.

An effort was made to educate the researched in the new paradigm, but this did then tend to induce in the participants' mind a feeling that the researcher was an expert, a situation found particularly in my own hospital, and which I feel exacerbated the feelings of ridicule for my methodology in particular and the topic in general. This role conflict between being

collaborative and being an expert, has been identified by Blackler and Brown (1983).

8.7.3. Publication and feedback of sensitive accounts

There may be dilemmas concerning publication of material that could be attributable to sources who gave information which they felt was confidential. I have therefore not identified quoted sources except to say whether doctor or manager, and to indicate their position. When trust appears to have been established participants seemed only too willing to talk freely and openly.

Backer (1969) makes two points about the ethics of publication, first that the researcher should feed back the information gained in order that those researched may benefit from it, and secondly that information not necessary to the argument or that would cause suffering out of proportion to its scientific value should not be published. As Miles (1979) points out there is no real possibility of real anonymity inside a site, but this research covers many sites, and individuals cannot be identified from the writings. However, on a more positive note, the sharing of the analysis may provide an important source of validation. I had then to be wary of people's attempts to portray themselves in a more favourable light by alterations to the accounts given and

by later discussions. I was aware of this problem particularly in my own hospital and have had to take definite steps to allow for this.

CHAPTER 9

METHODOLOGY

Decision and Practice

9.0. Introduction

According to Lincoln and Guba (1985) the design of a naturalistic inquiry cannot be given in advance but must emerge as the study proceeds and always take place in the field not in contrived settings. Even at an early stage certain decisions had to be made with regard to the method of inquiry.

The study takes place within the setting of the running of a major hospital and concerns the role of the doctor (i.e. consultant or specialist but known in America as a physician) in managing that organization. It does not study the role of clinical decision making.

In this chapter I will explain how the study is built up from various sub-units attached to the main core, how and why the various hospitals, units, Clinical Directors and Managers were chosen to be included and what I have done not only to gain their cooperation but also what I have tried to do with the data, and how this has produced useful information. I will further describe the actual

practical activities undertaken with the various individuals and groups.

9.1. General Plan

9.1.1. Consultants

First the consultants involved in the project are those who have been elected, selected, or otherwise chosen or volunteered to be Chairmen of Faculties, Heads of Departments or Clinical Directors either now or in the past. This title has slightly different meanings in various hospitals, but all of them, as far as this study is concerned, have some role and function of being partly or jointly responsible for the decision making and budgetary control of some part of the clinical aspect of the hospital. The only differences are in the size of unit for which they are responsible, the amount of responsibility and the degree of authority and accountability. All of these factors depend on the degree of decentralization or devolvement of central management in the institution. In some hospitals each and every clinical faculty or department has a Clinical Director, but none is represented on the Hospital Board. Whereas in other hospitals there are fewer Clinical Directors who each have responsibility for more than one faculty or department, and they all sit on the Hospital Board.

9.1.2. Managers

There is a dual hierarchical structure in hospital, (professionals and managers), and much of the day to day "running" of a hospital is of no direct interest to the doctors, and forms no part of this thesis. What is of interest to both doctors and managers is the control of overall medical and clinical activity rather than the control of diagnosis, investigation and treatment which is primarily of interest to doctors rather than managers except when significantly affecting financial performance. So I have considered managers as part of the study, and I have set out in separate chapters the history of professional management in hospitals, together with the changing relationship between professional management and the medical profession, as well as the reasons for arriving at the present situation.

9.2. Outline of Study

The main backbone of the project is a study of the management, decision making process and change within my own National Health Service District General Hospital. I have tried to study this at three levels, as Clinical Director and previously as Chairman of a Faculty and Division within the hospital; as a member on the Medical Executive Committee on which all the Clinical Directors

sit; as an observer of the Management Board on which originally three Clinical Directors sat. The last has sadly not proved possible. After I had carried out an initial interview the Chief Executive agreed to my suggestion that I sit in as an observer provided that I obtain the agreement of everyone else on the Management Board i.e. the Medical Director, the Nursing Director, the Human Resource Director, the Finance Director, the Medical Director and the three Clinical Directors. Within a matter of hours I had obtained the full and enthusiastic agreement of all of them except one clinical director. While he agreed to the idea he was not prepared to give me any time for a form of research which he scoffed at. Even that I felt was relevant to my previous impressions and would have been surprised had I not found one sceptic amongst the doctors.

However in spite of three approaches to the manager over the ensuing months, two in writing, for an invitation to the Management Board meetings nothing was forthcoming. This omission at my own hospital was however filled by attending Board meetings, at other hospitals both in the UK and America. It was interesting that over the ensuing months one Clinical Director ceased to serve on the Management Board for personal reasons, followed by the Medical Director through ill health, and he was replaced by two of the Clinical Directors in a joint Medical Director role, a subject of discussion in a later

chapter. As a result they were obliged to give up their Clinical Director role and the Clinical Directors were instead replaced by a Medical Services Manager, a Surgical Services Manager, a Clinical Services Manager and a Business and Facilities Manager, none of whom was medically qualified. Thus all Clinical Director input was effectively removed from the Board.

Because I work in this District General Hospital I know and therefore have access to the Managers and Clinical Directors in a way that would not be possible to an outsider. I know them well and the hospital organizational structure is one that I am familiar with. Nevertheless I was unprepared for some of the initial subtle and not so subtle hostility towards the project from some of the managers and doctors in my own hospital something, I have not found in other hospitals either in the U.K. or America. I was therefore surprised that although there were open and explicit requests for the use of the findings of my research, when I produced papers on the topics requested, they invariably met with a lack of response or at most a comment that the subject was "interesting", but nothing more. So my lasting impression was not of hostility but lack of interest, which on reflection was not a surprise.

Although the study actually "crosses" the boundary between two eras in the Health Service, the introduction

of the radical changes in the White Paper (HMSO.1989) it is possible that this may have had an effect on some of the relationships within the hospital, but this fieldwork has been structured to study the situation "post" the changes.

Secondly but in a "fleshing out" role is the study of Clinical Directors and Managers at various other District General Hospitals around the country. I have set out the reasons for the choice of centres and the different methodology for this part of the study.

Lastly I will be drawing on data from a study of the role of doctors in management in the United States of America, using a similar methodology to that for the comparable second part of the study mentioned above. I will also elaborate on the motive and the importance of including this aspect in the work.

9.3. Methodological Approaches

This study is loosely based on "co-operative" inquiry but not the new paradigm for research explored by Reason and Rowan (1981) which breaks down the traditional distinction between the role of the researcher and the subject. It is firmly bedded in the middle ground of ethnomethodology or participant comprehension. Still far removed from the positivistic methods succinctly

described by Heron (1988). In the old paradigm only the researchers do the thinking that generates, designs, manages and draws conclusions from the research; and only the subjects - often knowing nothing of what the researchers are aiming for - are involved in the action and experience which the research is about.

While I did not undertake the research with the subjects as co-researchers they did help devise, manage and draw conclusions from the research; and they also underwent the experiences and performed the actions that were being researched.

In collecting data from Clinical Directors and Managers from other units and particularly from the United States it would not have been practical to use the same methods. I therefore devised a method based on the concepts of the ethnomethodological approach but adapted to fit the practicalities of the data collection. This I have outlined.

9.4. Choice of Units

In Chapter 1 Section 1.6.4. I have given details of the scope of the project: 60 NHS Consultants, 18 NHS Managers, from 13 NHS Hospitals. The hospitals other than my own were chosen and added as the project proceeded by personal contact, networking, the hospitals' interest in

my project, recommendation of interviewees, and my attempts to include as broad a spectrum as possible to include Directly Managed Units (DMU) and Trusts, large and small hospitals and Teaching Hospitals as well as District General Hospitals (DGH).

In the United States I interviewed 27 Consultants and 13 Administrators at 6 hospitals. These were chosen by writing to my opposite number in 18 hospitals asking if they and their hospital would be interested in participating in the project. I received 8 replies all favourable and chose 4 centres in different States, as laws vary from State to State. They then set up and chose the participants for me. In two cases they arranged visits to another hospital, hence the 6 hospitals from 4 centres. I would have liked to have visited the other 4 centres (in different States) but the centres visited had already taken me away from my clinical work for three months in two visits.

The main unit, the centre of the study, is my own District General Hospital, one of the largest in the country with a catchment population in excess of 420,000. I have worked there for over twenty years and have seen many changes occur not only in the National Health Service but in this particular hospital. I know the organization, finances, workforce, management and morale, as well as the Managers and Clinical Directors and I have

easy access to them. I therefore have the benefit not granted to an outsider of being close enough to these people for them to be honest with me and tell me what they think and feel, perhaps in blunt terms.

There is however, another side to this coin. I have spoken in the earlier Chapter on bias, the bias of my involvement. This familiarity might perhaps be an opportunity for bias from the subjects of the research, an opportunity for "axes to be ground". I see this as a strength of my position however, because after recognizing this possibility I do have the opportunity to get hard, heartfelt feelings.

I wanted to avoid the bias of researching only people I knew well and therefore decided to expand the data collection by going out into other districts and interviewing other Clinical Directors and Managers.

It would have been easy, in an attempt to reduce the complexity of the situation, to have only included certain fixed subjects, i.e. only Clinical Directors and General Managers. So I chose deliberately to increase the opportunity to examine data from as many viewpoints as possible, not just that of the Clinical Directors, to have as many groups as I could manage, including Regional Medical Officers, Governmental Medical Officers and Health Care Academics giving a view, looking at the data,

reflecting on it, feeding back interpretation of the data, testing the information to make the conclusions as reliable as possible.

The most obvious diverse element between the professional and the managerial or administrative career background is that they both have smug, stereotypical and critical views of each other. I made no attempt to study only those outside groups which had been particularly notable in their successes and had therefore received notoriety for this feature. I have included some minimal data input from other human service organizations. I initially thought that because of the different funding arrangements for private and American hospitals the data would not be solely applicable to the Public Sector. However the U.S.health care system is undergoing changes which will leave their hospital services more like our own. The health maintenance organizations, H.M.O.'s, which purchase healthcare, are looking more at costs and are seeking to rationalize the contracts they have with hospitals. Hospitals are having to justify their costs and translate prices into perceived value. Although the funding of health care in the U.K. and the U.S. are different with different customer groups, the new fundamentals of marketing now remain the same.

9.5. The Gender Issue

Finally on the question of gender, no attempt was made to limit the study to male or females, but in fact I could find no female Clinical Directors let alone any who were prepared to participate in the study in this country. In the U.S. group there is one female Clinical Director. Also in the U.S. group there was a moderate proportion of female managers.

9.6. Activities Undertaken

9.6.1. Committees and Boards

At the start of the project I approached the District General Manager for his approval to carry out the study within the District General Hospital. I then approached the Unit General Manager to obtain his approval and cooperation in the project, together with similar approaches to all the Clinical Directors on the Hospital Board. I have already described my experience with them above. The Unit General Manager, now the Chief Executive Officer and the Chairman of the Hospital Board, agreed to approach the management/administrative members of the board although subsequently he asked me to make my own approach. This is described above.

I explained to each member the background and purpose of the study and outlined the concept of postpositivistic thinking. All have been supportive and agreed to participate and also to contribute. As described above one Clinical Director regards the whole notion of management studies as valueless and indeed no more than a joke and has taken a very negative attitude to the whole project. He did however agree not to block my study but made no active contribution. If anything however, it made the attitude of the other members of the Board more supportive and constructive. I explained the time commitment required of them and gave assurances on confidentiality.

I was to attend as observer at a series of Board Meetings which are held monthly and feed back any information or data to individual members in a series of separate meetings to discuss it. At the end of meetings I would have been given time to review data and thoughts with the group as a whole. Unfortunately as described above this was not to prove possible. Lastly I had hoped at the end of the data gathering session to have a meeting held solely with the purpose of obtaining feedback and response from the group. This has also not proved possible at my own hospital for reasons given above. I was however asked to write a paper for the Board and Medical Executive Committee on how consultants could be more involved in the management of my own hospital. This

resulted in two meetings of the M.E.C., one of which devoted considerable time a discussion on this and the second was devoted entirely to a feedback on this document. As a result I had a good opportunity for validation and review with some of the participants of the whole project.

9.6.2. Interviews

There is an extensive literature on interviews revealing a vast variety of interviewing procedures (Richardson et al 1965). A typology according to Massarik (1981) describes the following types of interviews:

The Hostile Interview.

Here there is mutual hostility between interviewer and interviewee. The interviewee may withhold information which the interviewer wants. As soon as minimum objectives are obtained or if the task appears useless to one or other, the interview terminates. An example is police interviewing suspect. Clearly this was inappropriate for my purpose.

The Limited Survey Interview.

Here there is relative indifference or minimum trust. Little consideration is given by the interviewer and the

interviewee response is one of minimal acquiescence. An example might be a market research poll where the questioner elicits responses almost automatically.

The Asymmetrical-Trust Interview

There is a substantial imbalance in the trust relationship. Typically the interviewee is more trustful of the interviewer although the latter is not hostile. A good example is patient and doctor or other professional interview. The interviewer is regarded as a counsel or source of wisdom.

The Rapport Interview.

This opens up a more human relationship between interviewer and interviewee to establish a rapport. There is some mutual trust, small talk, and interpersonal activity. The interviewer is acting a role but not denying their personality and individuality. An example might be a high quality survey interview, with open ended questions, with cooperative information seeking and giving etc.

The Depth Interview.

Here the interviewer tries to explore the views of the interviewee more thoroughly than in the rapport

interview. The level of rapport is also greatly elevated. They meet as peers. The interviewer is concerned for interviewee as a person and this feeling is reciprocated. The time frame being not tightly constrained, the interviewee may also ask questions, exploring, seeking clarification and actively participating in the process. Examples include open ended market research, journalistic inquiries and some clinical interviews.

The Phenomenal Interview.

Here there is maximum trust, the interview attains a genuine and deep experience, with a caring relationship between interviewer and interviewee and a commitment to a joint search for shared understanding. Both respond as total persons, ready to examine, disclose and share experiences, responses and thoughts. They meet as companions. Here there is a joint commitment to the job in hand. The time frame is fluid. Ideas may be set aside and re-examined later in a changed context. There is little simple question and answer, but rather free form communication with review and clarification of thoughts and issues.

Value of Interviews.

I was concerned about the interviews being research rather than journalism. Journalists plan an

investigation, interview people, ask pertinent questions, perhaps uncover new facts, reach conclusions, check facts from more than one source, communicate the results etc. I had to be sure that what I did was research and not journalism. Reason and Rowan (1981) in discussing issues of validity gave me some clear ideas on this.

They accept that some researchers might begin with unstructured interviews as might journalists, that they both might produce theories, and that they both might check their findings from different directions, the researcher by asking peers about peers or the journalist by comparing accounts of different investigators. So what do they feel are the important differences?

They feel the key difference is that the researcher went round the cycle more times. Over and over again he interviewed, theorized, fed back theories, interviewed more, theorized, fed back, tried out, interviewed... over and over again checking impressions, tentative conclusions, concepts, refining and clarifying and deepening and differentiating them;

> "When [the researcher] finally wrote his book it was with a sense of having reached a reasonably stable point in the process."
>
> "[The journalist] on the other hand did what amounted to just one round..... did not make the same number of opportunities to check [the] data. A journalistic inquiry tends therefore to be relatively impressionistic."

A characteristic of good research is that it goes back to the participants with the tentative results and refines them in the light of the participants' reactions. Reason and Rowan (1981:248):

> "Another difference seems to be that journalists tend not to feed back to their subjects the conclusions they are coming to."

The key question was how to turn the interviews into research. Reason and Rowan explain (1981:248);

> "Instead of an "unstructured" approach, which simply leaves the way open for all the cultural expectations to get in the way of finding anything out, there needs to be an approach which deliberately opens up the area, and gives explicit permission to explore usually *unacknowledged* realities."

There needed to be an involvement with the person which enabled a process of correction of impressions to take place. This did not exclude the possibility of the interviewee doing some theorizing and some checking too. As Sims (1981) shows, under the right conditions "interviewees" can quite easily turn themselves into co-researchers.

So it was important that instead of a single cycle of data collection, there had to be multiple cycles, where the theories and concepts were progressively extended,

refined, differentiated and integrated reaching towards a theoretical saturation.

9.6.3. Individual Interviews

I have already referred to the scope of the interviews in Section 1.6.4. on Data Collection in Chapter 1. There were a total of 118 interviews taking in excess of 200 hours and this together with notes and transcripts of parts of meetings and feedback sessions produced transcripts totalling more than 500,000 words.

The aim of the project was to try for as many "phenomenal" type interviews as possible. Some achieved this but many fell short into the "depth interview". Unfortunately some fell below this to a "rapport" type of interview. Only one was almost "hostile" in the sense that the interviewee was reluctant to give any information. When asked, for example, after considerable evasion on any question, to express his feelings about the way doctors are involved in the running of a hospital one American doctor said:

> "Well I have no feelings in the matter".
>
> AW: Do you think doctors do know enough about the management of hospitals?
>
> Doctor: I will answer you that, if you will tell me one subject on which doctors do know enough.
>
> AW: Do you think they might benefit knowing more?

Doctor: The same answer.

AW: Would you like to see their level of knowledge improved?

Doctor: I am not in a position to prescribe for the physicians with respect to their education.

The participants were all given a list of topics covering no more than half an A4 sheet some days ahead of the interview. The interviews lasted anything from an hour to four hours when the subject was allowed to talk freely about the subject in any way they chose. The technique was to use reflective listening and only interrupt the discussion if it were to get well away from the topics of interest.

I originally began with a rigid series of questions similar and related for both doctors and managers. The initial interviews were tape recorded in addition to my taking written notes. Questions were considered under three basic headings:

Are you a manager?

The why, how and the preparation for this role.

The management role of the interviewee.

Asking about the details of what the subject actually does on a daily basis.

Management relationships.

How did the interviewee see it developing and what changes were envisaged?

Specific questions.

About topics such as consultant power and influence. What changes are occurring. How they were coping with changes.

The questions were specific and too much like a questionnaire even though I had tried to avoid that. Notes are taken of the main points raised and after the interview a recording made of my immediate post interview impressions. These two recordings were transcribed and these together with the notes were used to construct a summary of the main points covering no more than two sides of an A4 sheet. This was posted to the interviewee who then had the opportunity to change anything which had been misunderstood, correct anything said in error, or add any additional thoughts.

The tape recording did not prove to be any problem and although the recorder is fairly large, the subjects soon warmed up and seemed to be unaware of the presence of the recorder. Occasionally a manager would ask for the recording to be stopped, a request I always complied with, although I was free to continue to take notes of what was said. This recording gives most of the factual

data on this aspect of the project. Interestingly one manager asked me to "switch off the machine in the interests of accuracy".

By listening again to the recordings and to a lesser extent by rereading the transcripts I discovered that I was forcing the participants to stick too closely to my agenda and preconceived ideas. So I developed my interview techniques, wishing that I had learnt this earlier, as I felt on reviewing some of the earlier interviews I could well have missed important data. As a result I found the later interviews much more valuable.

Having again reminded the interviewee of the meeting a few days ahead, and included a set of broad topic outlines I use the following approach to the interview.

1. Having introduced myself and the research I confirmed that the interviewee was happy for me to use the tape recorder.

2. I then asked about the participant, his job title, what it was, what he did, and generally what it involved. I asked about how they fitted into the organization, who they reported to and who they directly supervised.

3. I asked questions about their career background, how they reached their present situation and their training for their managerial role.

4. I then moved into the topics previously outlined to them:

   Their views of the role of doctors in running a District General Hospital and how this has changed and the likely future developments.

   The power of the medical profession and clinical freedom, past, present and future.

   The relationship between manager and consultants, how this has changed and likely future developments.

Factors discussed included the practical aspects of managing, and the relationships between doctors and managers including preconceptions and experiences. I also explored their vision of future developments. But I made no attempt to keep them to this if they were happy to talk freely once started. This is a theme which I return to in Chapter 19 on my personal learning curve.

In general doctors and mangers agree about more things than otherwise, and relationships improve or deteriorate

on beliefs they have of each other rather than accurate perceptions of each other.

The United States study followed a similar pattern. The centres were chosen by selecting a centre in a number of States across the country where I had been able to identify heads of departments of my own speciality. I then wrote to these individuals by name outlining my project and about three quarters replied within a month, all expressing a willingness to participate. From that collection I selected four centres, who seemed most enthusiastic and from which I could visit the most hospitals. Each example comes from a separate State where the regulations and laws are slightly different They include both large University units as well as smaller non teaching hospitals, Veterans Administration hospitals, private hospitals, Community hospitals and religious hospitals where money is not such an overriding issue. This gave a spread of views of both larger and smaller units than my own which is a large postgraduate teaching hospital.

9.6.4. Feedback After the Interviews

Reason and Rowan (1981:249) feel that it is important that instead of a single cycle of data collection, there had to be multiple cycles, where the theories and concepts were progressively extended, refined,

differentiated and integrated reaching towards a theoretical saturation. This has been described in Chapter 7 and only when this saturation point had been reached with the Clinical Directors did I feel able to move on to the next stage of interviewing participants outside district level, but those who had regional or national roles and the academics in the field.

9.7. Personal Lessons

From the outset of the project I kept a diary of thoughts, ideas and my learning experiences. My background is in medicine and I felt pretty ignorant of social science, so I knew that I initially had a lot of reading to do. This was a time of intense background reading on experimental methods and post-postitivistic methodology. About errors, experimenter influence, and how profound discoveries can be made by those who, while playing a part, can still be their own observer. After reading a number of key authors, I found they were referring to each other's work and there was a sense that I might have grasped what the main issues were.

Six months into the project I was introduced to the idea of the cognitive map, (Eden, Jones and Sims 1983) and used this in developing ideas, reviewing data, in discussions with participants and groups and writing up. I drew one map out on an A4 sheet of paper and within

weeks there where the equivalent of a hundred A4 sheets taped together (albeit with felt tip writing) and I then realized the extent of my task ahead.

It led me back again to the question of management of hospitals and the values of doctors and managers and questioning whether the profession had abdicated its responsibility to the administrators. Part of the map was leading to the idea of training doctors for managerial roles, combined medical management degrees, or staff college concepts, but to transfer from an M Phil to the PhD I had to produce something in writing on what I had so far achieved, and this occupied some weeks. I produced some 20,000 words most of which I now regard as immature, naive and second rate padding. I cringe to read it now. At the interview my worst fears were confirmed, what I was doing and how was not clear and I needed more detail on my methodology.

I needed something positive to come from this so I immediately went and arranged with the Executive Directors of a hospital to interview them and sit in on their meetings. One Medical Director was very negative and dismissive of the whole project but I was comfortable to accept that, as perhaps he felt the issue was threatening. At this suggestion he became extremely defensive but I let the matter rest there. During the

next week or so I rewrote two chapters on Methodology which have formed the basis of those in the thesis.

So the first year ended, I felt frustrated that to date I had not interviewed a single person, and could only discuss what I had discovered from the literature. But I did have a much clearer idea of what I was doing, how to do it, and why etc.

I tape recorded virtually all my interviews and have been able to relisten to them and mentally return and catch the nuances of meaning which I missed while concentrating and making notes. I suspect this information because the body language is missing, although the longer the interview the more reliable I felt the information became. This was partly because an atmosphere of trust was being built up between the participant and myself. But I had no way of telling whether the participant was really revealing his true thoughts initially, and this was confirmed by some interviewees who changed their views and information as trust developed.

But I have also recognized the occasions when I have missed data by interrupting. I learnt early on by listening to my interviews that I was forcing the participants to stick too closely to my agenda and preconceived ideas. As I developed my interview techniques I wished that I could have learnt this earlier

as I felt that on reviewing the earlier interviews I could well have missed important information. As a result I found the later interviews much more valuable.

9.8. Fieldwork

My first year of fieldwork both in this country and America was both daunting and exhilarating. An abiding memory will be of landing in San Fransisco in the early hours of the morning after a 27 hour journey to find a series of interviews arranged for me at Stanford University Hospital, beginning with the President six hours later. It gave me a great sense of achievement that I felt the interview went well despite being heavily jet lagged and more than a little awestruck at the cultural differences between that hospital and my own.

One of the biggest disappointments arose in that the sheer volume of work involved in the transcription and selection of essential data for validation. The great amount of enthusiasm that had seemed present while in America apparently faded and a number of the validations were never returned. Again I found this very discouraging as it seemed that although this was an important subject to me I had failed to express this adequately.

On returning to this country it was very hard to begin interviewing again. I had begun to feel that the Americans were more inclined to change and move forward whereas in this country everyone seemed to want to keep things as they were. It became clear, that there was going to be far too much data for the thesis, but it was proving difficult to know where to stop even though it was becoming obvious that I could gather little more new information, it was beginning to become repetitive. Eventually a decision was reached that no more routine interviews would take place and that I would begin writing. I was however, to carry on with interviews of some academics and attending workshops and seminars for continuing feedback on ideas and theories.

Everything went without too much of a problem. Sometimes interviewees took me to lunch which made it difficult to record or take notes so that I had to resort to memory and tape recording and making notes immediately after the interviews. I am sure this gave me less information as the transcriptions and recording have been immensely helpful for second and third trawls for information, as well as looking for appropriate quotations. Only one interviewee refused to accept the idea of validation saying she stuck by what she said, she knew what she had said and would wish to change nothing. I suspect, looking back at the interviews, although time consuming and sometimes of little use they were becoming

fascinating in themselves. I was enjoying my new found ability to meet new people, to listen objectively and to learn and not least share ideas with people of like mind.

About this time I was approached by the Open University to write for them on a Module to be published in a few months, and I was asked to take part in a Wessex Regional Workshop on Managing Change and to run a module of a workshop for Clinical Directors and their Business Managers in Wessex on Models of Clinical Management in September. I was also being overwhelmed by the number of meetings arranged with Clinical Directors and Hospital Managers so my wife helped out by taking over some of the interviewing. No sooner was that organized when I was approached to write a book for Hodder and Stoughton the title to be "Management for Clinicians".

I felt the pressure was on now. I reconsidered the problem of the validations which were attempting to sometimes reduce seventy pages of typescript to two. It was time consuming and I was anxious that I might be losing some of the essentials in such a drastic reduction exercise, particularly when some people have a lot of useful thoughts. In those cases I need the ability to keep more. Some people had so little substance of use in the transcript that I do not need the two sheets.
I was also still behind with the USA summaries although managing to keep up to date with the UK ones. I decided

to try catching up by merely going through the outstanding transcripts and cutting out the "waffle", the irrelevancies, the repeats etc.

By now I was hearing the same answers to the questions, nothing different seemed to be emerging. I felt that there was nothing further to be gained by asking any more clinical directors or managers these questions. I began to ask different questions but still tended to receive the same information.

It seemed as if nothing has changed in many respects since before the reforms in the NHS. This appears to be a combination of factors, the relative strength of each depending on the hospital. The doctors through lack of initiative, lack of understanding, lack of time, disinterest, unwillingness to take over. And for the Managers through lack of understanding or unwillingness to let go.

Time was definitely becoming a problem and with increasing numbers of commitments of my time as a result of my work I was now not doing any more extra work but concentrating on starting the writing of the thesis. My book was finished and with the publishers so over one weekend I drew up a plan of the remaining time and how it was to be utilised.

One of the main problems that I have encountered is the assumption by many of my peers and indeed my employers that the study and information I have gleaned can and should be used at the very many conferences, seminars and workshops that I have become increasingly involved with. This situation arose partly from my own research and interest but also from the changes taking place within the health service.

Many of the meetings were time consuming and often boring and I found that as the project continued I often found myself better informed than many of the others present. I was fast becoming an expert in the field. This produced conflicts with peer groups within my own hospital who found this enthusiasm and knowledge alarming, and possibly threatening. This has been something of a problem in my relationships with colleagues and I am very aware that at times I have been less than tolerant with them. This may be because I have felt that I would like to convert many of them to my views, and any lack of enthusiasm I have often detected as my failure to do so.

It became apparent very early in the project that my subject was highly topical and I have found it impossible to refuse these invitations. This was partly because the Health Authority were funding my University fees, but mostly because I have looked on each additional task as

part of my learning process. I am basically a very shy person and have previously used the mystique of medicine to act as a shield when dealing with patients. This has largely changed as the work has progressed I have learnt to listen and to hear what is being said. It has not been easy, as medical training has not only been strictly science based, but has ingrained the feeling that people want my views and over years an insidious arrogance can build up.

There did not seem to be much interest in using what I have learned at my own hospital. Although the book had been enthusiastically received by the publishers there was not going to be a living in writing such books. And the health service did not seem interested in spending any money on improving the involvement of doctors in management as all the courses I ran I did for travelling expenses only. I had serious thoughts about what to do with what I had learned when the thesis is written. However, a useful tutorial gave me some insights into how I might plan future developments after the thesis is written. I learnt to be patient and wait. I should say that I always found my tutorials of great benefit. My tutor was unfailingly encouraging and I invariably came away feeling inspired to continue.

Well into the third year I received a letter from the Chief Executive of my own hospital asking me to write a

paper for discussion on the structure of the Clinical Directorates and how it should be organised in the future. It received a mixed response but little changed.

9.9. The Emerging Thesis

The thesis was beginning to emerge as a total plan now, as were plans and ideas for the future. I was also embarking on a massive final read of about two dozen books which I have been putting "on hold" through pressure of other things. Every now and then I found a statement of something which I had previously considered an original personal thought or idea. Rather like Handy's "Gods of Management" right at the beginning. I could see my thesis ending up as a jigsaw of ideas from diverse sources being collected together to make a different but perhaps not new picture. But then someone once said a painting is only a different arrangement of existing colours invented by others. The picture was becoming clearer and the loose pieces fewer so there was less choice about where to put them.

I wrote a summary section of three pages to outline the design and layout and ran through the arguments to conceptualize my idea of the dissertation and this acts as a sort of map for anyone reading it. The summaries which I took from all the interviews now seem to concentrate on the wrong issues. I would now do things

differently if I were starting again. As Diesing (1972:20) says;

> My cry is the cry of all fledgling field workers: "If only I had known at the beginning of my field work what I know now, I would have done so much better!"

The problem was that these details cannot be learnt in advance from books or others, they come from getting into the subject, learning from the project as it develops, adapting to new ideas as they occur and generally being flexible, but necessarily critical and thoughtful, in the approach to the research. I hope however that I have at least reached what Gluckman (Epstein 1967:xiii) calls "the method of apt illustration" or which Diesing (1972:20) describes as a step higher up the ladder than the traveller's report."

It was so lucky the interviews were transcribed and also having a search facility on the word processor I could find important text to support my writing.

I was beginning to see a picture emerging from the fog of data, an outline of how sections should go. I was much heartened when I read a whole book over a weekend about the NHS and the new management structure and thought they had mis-interpreted Griffiths in particular. At last I felt I had a real grasp on some of the subject and could be more critical of what I read and heard. At last I was

beginning to have a real confidence in my own interpretation of events. Re-reading some of the original books I had begun with, now embued with the data of my own research findings, has also been a new learning experience, revealing different aspects and suggesting new approaches.

I had so much data it was actually quite difficult to handle. I have taken to writing a chapter using a cognitive map to create the headings and subheadings and contents for each chapter. This made it easier to keep the thread of the argument on track.

An American Medical Company contacted me to discuss the offer of an appointment as Chief Executive or Medical Director. I also attended workshop at the Royal College of Physicians on Clinical Directorates. This was very useful as a feedback for my thesis because here were people who came from hospitals where it was working. My own hospital seemed to remain centralised because the consultants did not want devolvement any more than management. Perhaps they have been unconsciously colluding together. I was surprised therefore, to be telephoned by a consultant to say that a group having met with General Practitioners had got together and written to the management expressing concern about the lack of locally devolved management.

Sad to relate that our own Chief Executive is now leaving to go to elsewhere. There is a certain feeling amongst the consultants of smugness that in spite of all the attempts to change the health service and controls in hospitals it was the Chief Manager who did not survive, whereas they as consultants are still there and have survived it all. On the other hand a few feel that perhaps we may now have the opportunity to get a new manager more willing to decentralize authority.

I have found the entire process of research and learning enormously stimulating. I hope it has made me more understanding and aware of the difficulties faced by doctors and managers in these times of great change. It has provided me with opportunities of putting the research into practice and enabled me to feel I am contributing in a useful and positive way.

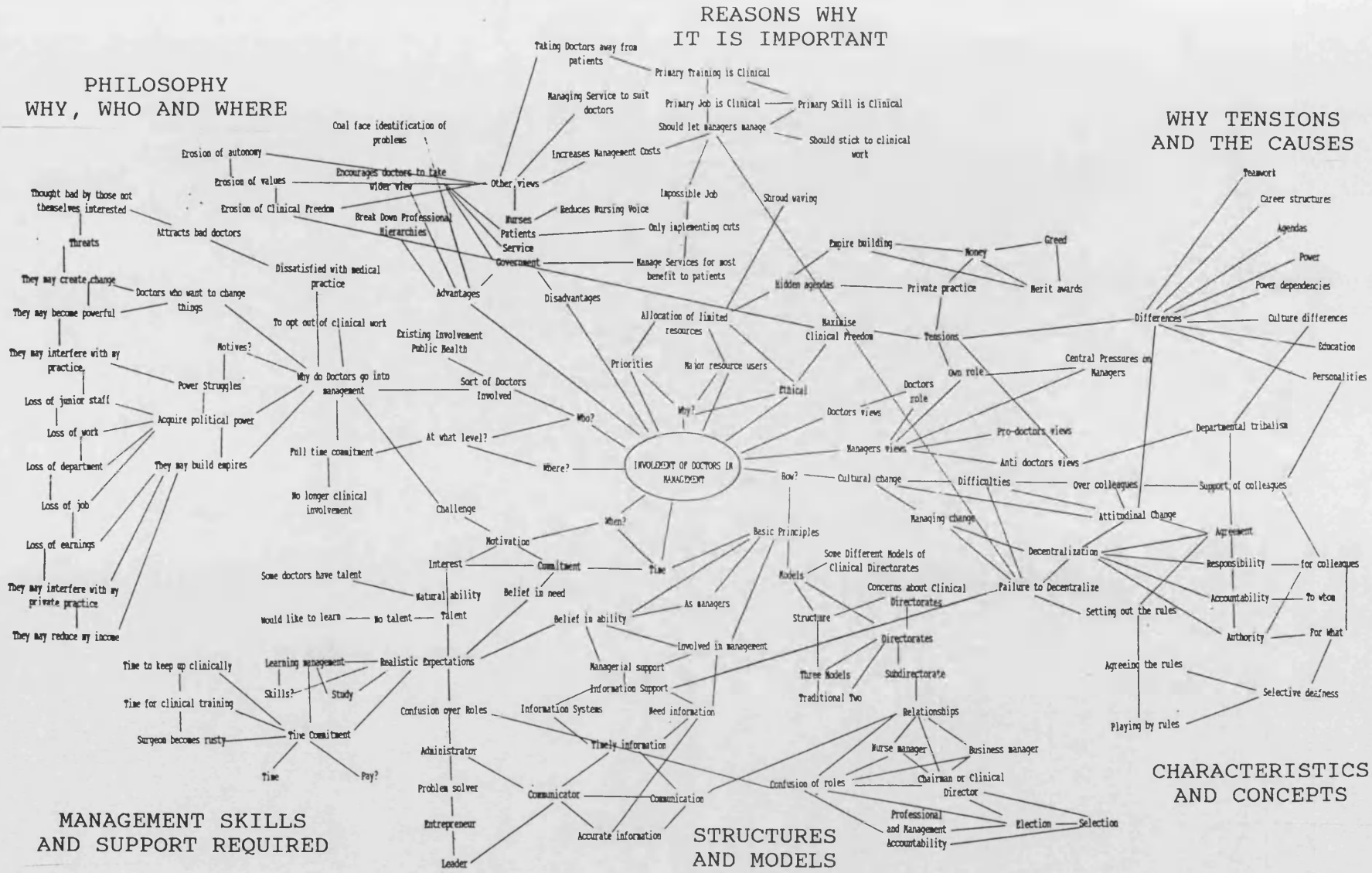
CHAPTER 10

PHILOSOPHY OF DOCTORS IN MANAGEMENT

10.0. Introduction

The next seven chapters comprising Part 4, I have constructed and written using fairly tight and discrete groupings within a cognitive map drawn up by the doctors and managers who have participated in this study and which has been added to both individually and at various groups, seminars and workshops. A very much simplified version of part of the map appears on the next page (p.247).

Certain distinct patterns emerged when I had amalgamated all the various maps produced by the various individuals and groups, and made any additions or corrections which the individuals or groups suggested. It was possible to divide the map into six main areas. The first is a philosophy of involving clinicians in management and which I address in this chapter. Next discussed in Chapter 11 are some of the reasons for involving clinicians in management, from both the doctors and managers viewpoint. This leads into a discussion of the tensions in these views which is the subject of Chapter 13. Chapter 14 addresses the issues of management skills, learning these and support for doctors in management roles. Chapter 15 then covers

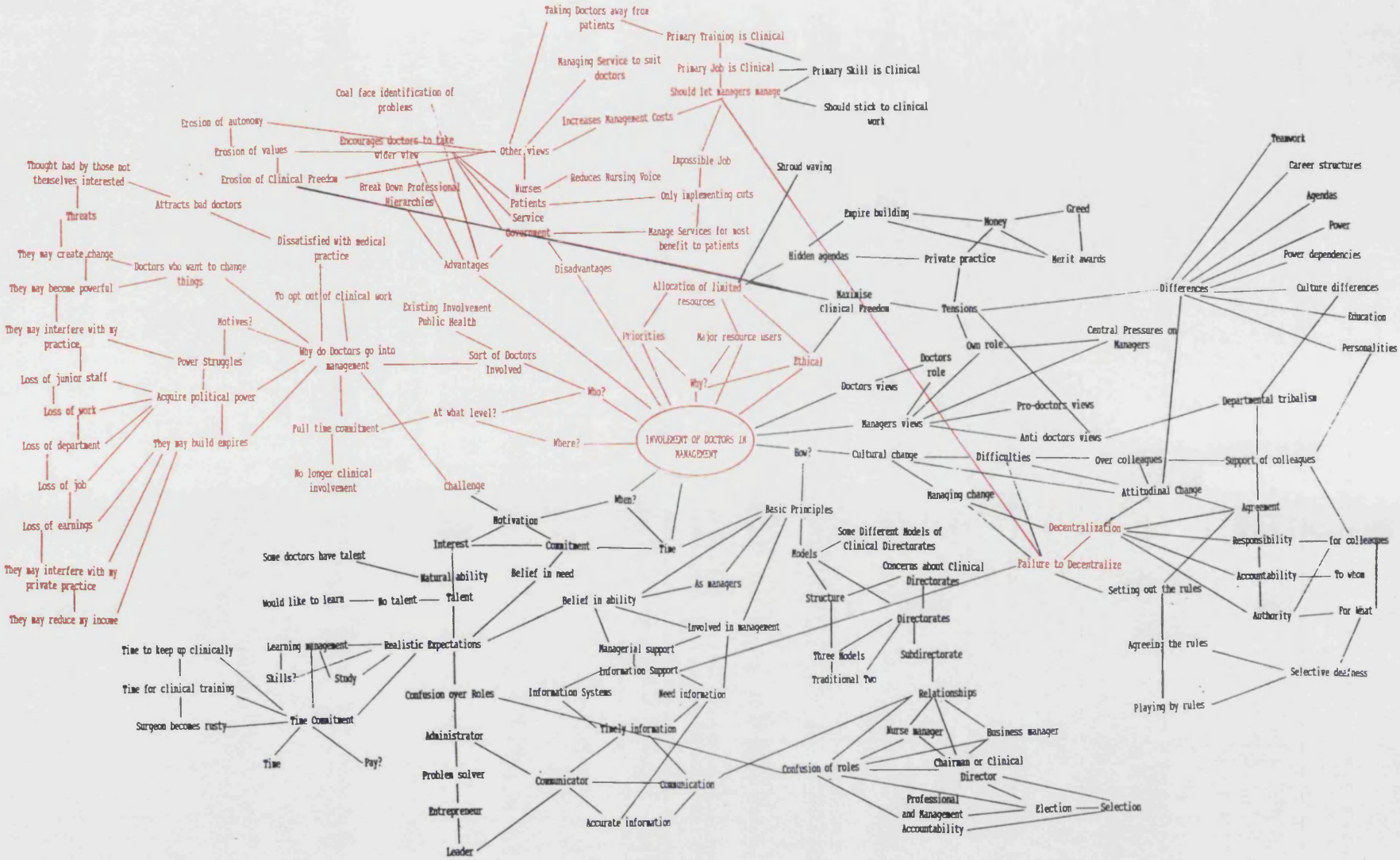


THE SIMPLIFIED COGNITIVE MAP

some of the emerging models and structures of clinical management. And finally in Chapter 16 the charcteristics of these models are revealed together with some of the problems that have been highlighted by interviewees.

At the beginning of each chapter is a copy of the simplified version of the cognitive map with the apects to be discussed in that chapter highlighted in red. The map relating to this chapter is on the following page. (p.249). Two further interesting items sprang from this exercise. Firstly that although there are various cross linkages between the groupings which I made for the practical purpose of writing about them, they all link with the concept of "decentralization" of management. This is not altogether surprising because when doctors become involved in management, as opposed to doctors becoming managers, devolution is necessary.

Secondly there is an area of the map which is not well covered by the groups referred to above, being "visited" only rarely, concerning the views of what sort of doctors are involving themselves in management, and why, and the possible disadvantages for doctors of being involved. In later feedback sessions it was therefore possible to highlight this and consider these issues and possible reasons.



COGNITIVE MAP CHAPTER 10
THE PHILOSOPHY OF WHY, WHO AND WHERE

Occasionally I refer to the literature during the data section; this is generally because one of the authors has been included amongst the participants interviewed, and the discussions with them have only amplified views they have written about in the published literature, and the written quotation remains the most succinct way of presenting their viewpoint.

In this chapter I will discuss the cultural differences that have emerged between doctors and managers, and the reasons for involving doctors in management from both the point of view of the doctors and the managers. It is also pertinent to point out that there is and always has been some existing involvement of doctors in management roles and I give as an example the role of Public Health and Community Physicians. Lastly I discuss the end of functional accounting and management in hospitals as clinical management takes over.

10.1. Cultural Differences

It has always seemed difficult to involve clinicians constructively in the problems of management, yet it is important that they should be involved. There have been few incentives to encourage doctors outside their own group or department. There is also a cost to the doctors themselves in increased workload, financial loss and tensions with colleagues. As one consultant put it;

> "It has always been somewhat difficult to be really involved, it takes up so much time, can cause problems with colleagues and all the meetings really eat into your practice."

The NHS Management Inquiry (DHSS 1983) known as the Griffith Report, was only one of a series of central initiatives for involving doctors more effectively in management, but it offered little practical advice as to how that could be achieved. One of the main issues appears to be the difficult relationship between doctors and managers, to which I devote chapters 12 and 13. There is a need to explore and understand the tensions existing between doctors and general managers, some of which are historical, others related to differences in training, the different contexts of their work and cultural differences.

Handy (1991) symbolised the different styles of management and cultures found in organizations. Apollo, the god of order and bureaucracy, the patron god of the role culture, based not on personalities, but on definition of the jobs to be done, and Dionysus, the preferred god of artists and professionals, within the culture of people who owe little or no allegiance to a boss:

> "Dionysians recognise no "boss", although they may accept co-ordination for their own long-term convenience. Management in their organisation is a chore, something that has to happen like housekeeping.

> And like a housekeeper, a manager has small renown: an administrator amongst the prima donnas is bottom of the status lists."

Unfortunately doctors, especially consultants, have a management style, which they often do not recognise as such and which might well be termed as arrogant, authoritarian, paternalistic or pompous. Wraith and Casey (1992b) in an Organizational Development Checklist for Clinical Directorates list nine items related to team work. The consultant should be a part of that team, however it is doubtful if many consultants understand the true nature of teamwork. And there seems to be no awareness of the need for what one consultant called "followership":

> "We talk a lot about leadership in medicine, we seldom talk about followership, talk about being the good citizen, without being the leader and I think that's something else that probably needs to be cultivated among medical staff."

Consultants only see themselves in the role of leader and like true Dionysians recognise no boss. One Consultant said:

> "We are the natural leaders."

10.2. Reasons for Involving Doctors

Authors all appear to agree that consultants have always had a major effect on the resources used. About 80% of

the costs involved in running a hospital are thought to be the direct result of doctors' orders (Klint 1992). And the DHSS (1989) support this view:

> "hospital consultants - whose decisions effectively commit substantial sums of money".

This view has been given to me from many sources but is typified by the President of an American University hospital;

> "Most people believe that at least 60% and perhaps up to 80% of costs in hospital are as a result of doctors orders."

Consultants respond to changes in demand for their services and to advances in scientific and medical technology. They usually make the judgements about the skills and interests needed to replace retiring colleagues and are responsible for other major matters of policy. Developments that seem natural and proper to clinicians may take resources away from other parts of the hospital and may well create problems for future planning in other departments. Historically, many consultants appear to have been concerned more with "empire building" and preservation of their individual practices, even to the extent of inappropriate appointments of colleagues, rather than wider issues of improvement in services to the public and appropriate use of resources. One Manager said:

"Doctors try to manage the service to suit the doctors. I see that as a big disadvantage of involving them more."

The major reasons Consultants give for the need to encourage more doctors to become involved in management seem to be a need:

1. To reduce costs.
2. To save money.
3. To reduce overspends.
4. Generally to assist with financial problems particularly of resource not matching demand.

Although Disken et al (1990) in a booklet produced by the Institute of Health Service Managers give as the reasons managers see for moving into some kind of clinical management:

1. Decentralisation and delegation.
2. To complement rapid developments in information systems.
3. To pave the way for new information systems
4. To break down barriers between professional hierarchies and groups.
5. To improve the quality of clinical services to patients.
6. To reduce the cost of high cost services.

7. To bring the consultants "on board" as a group.

8. To allow more explicit evaluation of clinical work and outcomes.

9. Severe financial problems

They go on to state:

> "that in most units there was a combination of such reasons and the roll out programme for resource management has speeded up the process of implementing clinical management structures. Reducing costs appears to have been the primary motivation in very few instances".

Though most managers reiterated the comments of the doctors with such remarks as:

> "We will get better value for money."
>
> "There will be coal face identification of problems."
>
> "It will help make savings and reduce our expenditure in a sensible rational way."

As doctors "allocate" a large percentage of the available resource it is felt that control could not be achieved without their cooperation and involvement.

However there are other reasons for doctors to be involved in management, as one Clinical Director said:

> "Within a cash limited system, the responsibility of doctors within the health service, which presumably strives for equity, changes; everybody has to be accountable for what they actually do."

According to (Chantler 1992b):

1. With limited resources, and increasing demands because of aging populations and scientific and technological changes, it would be unethical for them not to be involved in deciding priorities.

2. It actually ensures that maximum clinical freedom continues because it ensures that the maximum, most efficient and effective use is made of the available resources.

The problem had always been that in clinical work consultants were not subject to any significant management control but worked in a professional hierarchy with considerable clinical freedom. Doctors at the outset of the NHS were given support services, placed under some relatively tight financial and administrative constraints, then left to get on with the service in the ways each doctor thought best. The doctors had no boss and their individual performance went unmonitored. British medicine was administered, not managed, although the attempts to alter this and control doctors, and the costs of their work, has not been just a U.K. phenomenon but appears to affect every Western industrialized country.

10.3.0. Existing Involvement of Doctors in Management

There is a long history of consultants being involved in management within the NHS going back to the old Medical Superintendent role. As one Consultant put it:

"They had responsibility for all aspects of hospital administration at the beginning of the health service. They knew the price of every everything and they worked from an office with one secretary and matron."

Another Consultant said:

"The Medical Superintendent was responsible for running the place on a day to day basis and he knew quite clearly that he had to deliver the hospital within the budget set by The Board of Governors."

These roles became less common and gradually lay or professional administrators took over the administration of the hospital, although the Bradbeer Report (1954) proposed the idea of a Medical Administrator.

10.3.1. Role of Public Health and Community Physicians

Many managers felt that those doctors, mainly in community medicine, were a failure although one or two had been outstanding. This failure may have been partly through lack of management training and experience. A Public Health doctor said:

"unless we put at least as much emphasis in public health doctors' training to the learning of management skills, as we do on the epidemiological skills, we're never going to get anywhere in being effective as Public Health Physicians."

Many community physicians were often thought to be incompetent, even within the limited role that the NHS then offered them, but some were also held to be grossly

partial to the medical profession which affected their judgement. As one manager observed:

> "You always knew he would side with the consultants no matter what the issue."

However lowly the status of Public Health or Community doctors within the medical profession, they were still members. One Public Health doctor said:

> "Now you can't run a health service without good public health function, and there is no doubt that the consensus teams had ineffectual Public Health Physicians, Community Doctors, as a general rule."

Another said;

> "..they fight their corner and I think they tend in the main to consider themselves representative of the medical profession."

Thus, far from fighting medical power, many supported it or alternatively were too weak to oppose it. Given these difficulties many general managers took a harsh view of this fledgling attempt to involve the medical profession in management. In the absence of powerful community physicians, the consultants all too readily had their own way. A Regional Public Health doctor said:

> "where there was research done looking at the consensus teams, the Community Physician usually came out looking the least effective person on the team."

If the quality of many community physicians was thought to be poor, some exceptions were still made. Whereas some managers thought that community medicine had largely failed in management terms they still singled out cases from other districts:

> "he was very good, a wheeler dealer getting in among the consultants."

> "in those districts where there was an effective Community Physician and effective General Manager, you could achieve an awful lot."

Another, although critical of community physicians elsewhere, was full of praise for the medical managers who worked in his authority and modest about his own relative abilities. As a Health Service academic put it:

> "There were a few visionaries and a few very good people, but they were relatively isolated."

So a rather uneasy marriage had existed between epidemiology, medical administration and the old Medical Officer of Health and Public Health functions. A Professor of Public Health medicine said:

> "it was a real horror story for a lot of them [the 1974 reorganization], they went through a dreadful time. Some of them survived that, but many of them struggled and never really adapted to the Health Service, so part of the reason for the shifting fortunes I think was that post 1974 there were a number of people who were really fishes out of water, who were never really quite clear about what was expected of them."

Another academic Public Health Physician who had studied the early post Griffith D.G.M.s said:

> "the strong impression we got was that they [the D.G.M.'s] desperately wanted good Community Medicine as it was then called, but they couldn't get it, and those that did get it valued it very highly."

10.4. The End of Functional Management

Strong and Robinson (1990) and others talk of Griffiths as a rise in the general standard of management and that, in respect of the elimination of functional management, is correct. But in referring to the 1984 reorganization Strong and Robinson (1990:25) suggested that where once doctors and nurses had been guaranteed seats on the board they were now pushed aside to make way for new general management. General Practitioners and consultants disappeared from the team. Now nurses could manage doctors and administrators could manage nurses. Districts removed purely clinical doctors from the management team (Strong and Robinson 1990:26). It seemed that government was no longer willing to share power with the medical profession, no longer content to leave matters in the hands of the doctors.

Indeed some managers viewed the reduction of the nursing voice as a distinct disadvantage because it placed too much emphasis on involving doctors in management;

"The reduction of the influence of nurses is regarded by some nurses as a walk over by the more powerful tribe. And I think it is a particularly unfortunate event after the results of Salmon and then the regrading. Their morale has been badly affected."

Strong and Robinson (1990:65) wrote about Griffiths:

"consensus management had to go. A loose tribal confederacy was no way to run a modern health service. Without just one central power, any group could run riot. If there was no firm leadership, nobody could be called to account. The core of the 1984 reorganization was, thus, the assertion of central managerial control."

They felt however that Griffiths was, in its own way, still consensus oriented (Strong and Robinson 1990:68) . There had however, been a huge change. The old consensus had been shaped by a team of nominal equals. Now just one person was in charge. Consensus, of a kind, still had to be reached, but general managers were in charge of the consensus.

As I have discussed elsewhere (see Chapter 2, Section 2.6.2) it is now claimed however that Griffiths was actually recommending delegation (Griffiths 1991), rather than the general management structure imposed on the health service:

"One or two things I did not intend. Whilst my name at the time was primarily connected with general management I personally took this as shorthand for the introduction of an effective management process. I did not intend that the result should be yet another profession in the National Health Service to work in parallel with the other professions."

And Griffiths (1992) spelt out the continued involvement of doctors even more clearly later:

> "From the very outset in 1983 I made it clear that I envisaged a strong role for doctors in the management of the NHS and my report subsequently confirmed this."

Indeed one of the aims of the White Paper in 1989 "Working for Patients" (DHSS 1989) had been;

> "to ensure that hospital consultants - whose decisions effectively commit substantial sums of money-are involved in the management of hospitals; are given responsibility for the use of resources; and are encouraged to use those resources more effectively."

A health care academic in discussing the historical origins of the notions of doctors being involved more in management, reinforced this view;

> "Griffiths really pushed it forward, the general management document really pushed it forward with a big push. Then there was the Resource Management Initiative which has become in some fields almost synonymous with the notion of Clinical Directors."

How this has been done in different hospitals has been an evolutionary process. Each has set up its own organizational structure, some indeed really making no change from existing structures apart from the changing of names or personnel or both as I discuss later in Chapter 15. However the government had with certainty

since the Griffith Report been attempting to involve doctors. (Pollitt et al 1988):

> "Since the NHS Management Inquiry of 1983 there has been a concerted effort, initiated by central government, to induce doctors to be more interested in (narrowly) costs and (more broadly) resource management."

Interestingly they state that a major factor is the difficulty of turning doctors into resource managers and what has made the whole issue harder to resolve is that NHS managers have:

> "demonstrated scarcely more enthusiasm for such attempts than have doctors."

According to one medically qualified C.E.O;

> "Before the National Health Service, when consultants were "honorary" they knew the price of every ampoule of catgut and worked within a very small budget, so that providing health care within a constrained budget was something very real to them. Before 1948 the role of doctors in cost containment in hospitals was perfectly understood, because the hospital never had enough money, and had a Medical Superintendant who knew too that he had to keep within the budget of the Trust Board. Managers now do not seem so obsessional about their budget, though they may talk about it a lot."

A manager put it like this:

> "The health service appears to have trained successive generations to the notion that the service is free, regardless of the ability to pay and regardless of the ability of the government to pay."

As one doctor manager put it:

> "There are still staff who say don't talk about money, when lives are at stake".

The latest reorganization is forcing people back to the allocation of health care within fixed resources. In the words of a doctor who has been a UGM:

> "The fundamental problem of the health service is the inability of any advanced health service to do everything possible to everybody's benefit. You can never fund yourself out of that problem and you can't manage yourself out of it either. That problem will always be there but it does have to be managed."

For the community physicians however the Griffiths reforms were a double edged sword. They were scarcely over the change or loss of jobs with the loss of the Areas when this new phase of the Griffiths reforms began. According to one Regional Community Physician:

> "Public Health Doctors felt that they had been squeezed out, a lot of them wanted to get the management jobs, but actually weren't up to it. And there was a strong feeling then that this part of the profession was going to fall apart because the managers had not supported Community Physicians."

10.5. The Rise of Clinical Management

The trend towards involving doctors in management in acute hospitals is not confined to the U.K. Its origins are usually traced back to the events at the Johns Hopkins Hospital in Baltimore between 1979-84 (Heyssell, 1984). According to Brody (1992) however, doctors at the

Johns Hopkins have been involved in management for over a hundred years.

If serious clinical management was wanted, something far more radical was needed. Not only did doctors appear to continue to have exceptional power, but there was also some organized professional resistance to any form of external monitoring of medical performance. And the White Paper (DHSS 1989) attempted to address some of these issues.

For Public Health doctors abruptly it was a new era, as one put it:

> "Suddenly it became recognised that a lot of the things that the Public Health had always advocated like rationally clear about what health services we actually required and trying to do something about making sure that what was being done was actually being effective. Loosely called assessment audit or evaluation, it suddenly became right at the front of things and there was almost reborn Public Health Profession, having all the required skills to carry out this huge agenda."

Their dilemma was that there might not now be enough of them left with the skills to deliver. He continued:

> "All of that is extremely difficult to do trying to handle all that, so there is the danger that we may again fail to deliver what is expected, because it is a totally unrealistic expectation."

Suddenly the underdogs of the profession had a key role and a feeling of new strength. Regional Medical Officer:

"I mean some of the Gung Ho Public Health Physicians which I spend my life now curbing, and saying "stop, because you are going to destroy relationships".

Public Health doctor:

We have one or two very macho Public Health Physicians now who believe they have all the answers."

As a result there seems to be a slightly paranoid feeling developing amongst clinicians that Public Health doctors now have a lot of power, that "there may be a certain settling of old scores". One put it to me:

"A consultant was saying the other day that I was the person, he understood, who would decide what he could and couldn't do, but I don't actually think that is remotely the case, or should be."

And one Public Health doctor admitted:

"Community Physicians did run into serious battles with consultants, occasionally won, but usually came away with a bloody nose and I guess it would be unusual given what people are like if they weren't going to start to use their new power to redress some of the battles they lost."

10.6. Professional and Management Accountability

In the early stages one of the issues frequently raised by managers was what they perceived as a possible problem with professional and management accountability. This division they felt would create difficulties. Nurses

could not report to doctors, consultants could not report to consultants. Consultants could not report to managers.

It is important to differentiate between professional and management accountability. A clinician is professionally accountable to his patient and this accountability is audited in various ways by the various professional bodies, The General Medical Council, The Specialist Associations, The Royal Colleges etc. Professional accountability lines are not changed; nurses report professionally to nurses, doctors to doctors.etc.
A Clinical Director said:

> "Professional and management accountability can be seen to be distinct and can be isolated from each other at least to a large extent."

And another Clinical Director put it in more detail;

> "I'm accountable as a doctor, professionally through the systems that you and I understand. Nurses are accountable professionally to the Director of Nursing and the RCN and the UKCC. We all have our professional lines of accountability. Management accountability for working in this place using public resources is separate. I'm accountable within this place, as a clinician, for the resources that I use and the services I provide, and we can separate the two."

And a Chief Executive;

> "At the moment in all our Clinical Directorates the doctor is the leader of the group, so you might say that the nurses are managerially accountable to a doctor. However not professionally, if the nurse/manager in that group is unhappy about the professional side of nursing within that group, she

goes to the Director of Nursing who can then intervene at a much higher level in the organization. It's never actually had to be used, but it exists and everybody knows it exits."

Although not everyone agrees about this clear cut distinction:

"There is a distinction between doctors who provide personal doctoring services within the NHS and others who are employed in the managerial hierarchy, and the argument basically goes, that for doctors who are employed in the business of providing services and care to individual patients on a personal accountability basis, there is complete exclusivity between that phenomenon and being in a managed position. You cannot be both; the argument then goes on that there tends to be a conflict between being in that position and being a manager of others and it all revolves around those arguments, and that in most situations it is not sensible to try and place every part time consultant, whose whole culture is different, into roles like that and pretend, as many are still doing, that they can be managerially accountable for staff and to the UGM or whatever."

Another line of reasoning put to me by a consultant who had managerial experience before the 1989 reforms was that irrespective of professional accountability a doctor has a responsibility to be managerially accountable for resources because:

"The remuneration of the clinician in the NHS comes from central government; it can be legitimately be represented as coming from the patient from whom it is raised by taxation and it is only reasonable that all staff should be accountable managerially for their use of resources within the institution for whom they work."

A final view put by a Chief Executive was that many individuals were already accountable in the NHS to people in different professional groups:

> "All staff are managerially accountable to individuals who often come from a different professional background."

One medically qualified ex UGM neatly summed it up as follows:

> "The Chief Nursing Officer is still responsible for managing nursing but not nurses."

10.7.0. Final Thoughts on Rarely Mentioned Topics

Having covered all the items which most often come up in discussing the philosophy of involving doctors in management it remains only to mention those aspects which attracted least attention for the reasons given, why some doctors are involving themselves in management and the possible disadvantages. I have already given some that were often introduced by managers.

10.7.1. The Sort of Doctors Involved in Management

Taking first the sort of doctors involving themselves, most criticism came from other doctors, who were not themselves involved; the usual and traditional accusation

was that management attracted only bad doctors who were failures at clinical work. A Consultant said:

"Only bad doctors go into management."

Some admitted that while this might have been possible in the past it is now necessary to be a successful clinician first in order to have credibility with clinical colleagues. Very many doctors, whether involved in management or not, and managers, stressed the need for a continuing clinical commitment to maintain this credibility.

The question to which I therefore sought an answer was, why did some doctors feel negative towards colleagues involved in management? A number of possible answers emerged:

"I suspect their [referring to colleagues involved in management] motives. They are trying to change things, and I'm happy with the ways things are. We don't need things being stirred up."

"They are trying to get power, playing by the new rules, and do some empire building."

"It's the new way to acquire power and tell us all what to do, but he is not going to interfere with my practice, no one tells me how to treat patients."

On the other hand some consultants recognized that though they might not like the idea of consultants involved in

management, if someone else did it and it suited their own purpose then they were happy with that arrangement;

> "We thought that if we have him in charge he will stop things being changed; there is no way he will let the managers change the way we run things, and we'll back him all the way."

Some doctors also pointed out that those doctors dissatisfied with medical work and wanting to go into management might serve some useful function. One Consultant typified this view:

> "Doctors in management serve a useful purpose as firstly they are at least trying to change things, and secondly it does enable those who have no desire for a management role, certainly at present, to opt out, as we will know it will not have to be our turn sometime in the future, as used to be the case."

Some doctors however accepted that it might not be unreasonable to involve doctors in clinical management, and that while they themselves might feel like a fish out of water, they would be very happy to support a colleague who had a talent for management:

> "to take on the role for us, particularly if his motives were right, and he felt the need of that sort of challenge."

10.7.2. The Disadvantages of Doctors' Involvement

The disadvantages were again largely identified by those doctors not involved, although acknowledged by those who

were involved. And again it revolved around the issue of motives. If the involvement was to acquire personal power, to control colleagues' activities, to build empires at the expense of corporate hospital goals, or to prevent changes then the opportunity for involving doctors was seen as a disadvantage. What was striking however was that the feeling was common that involvement was advantageous to the hospital, the patient and the service, whereas the disadvantages were more difficult to tease out. However this might be a reflection of the fact that the majority of the participants were doctors involved in management.

CHAPTER 11

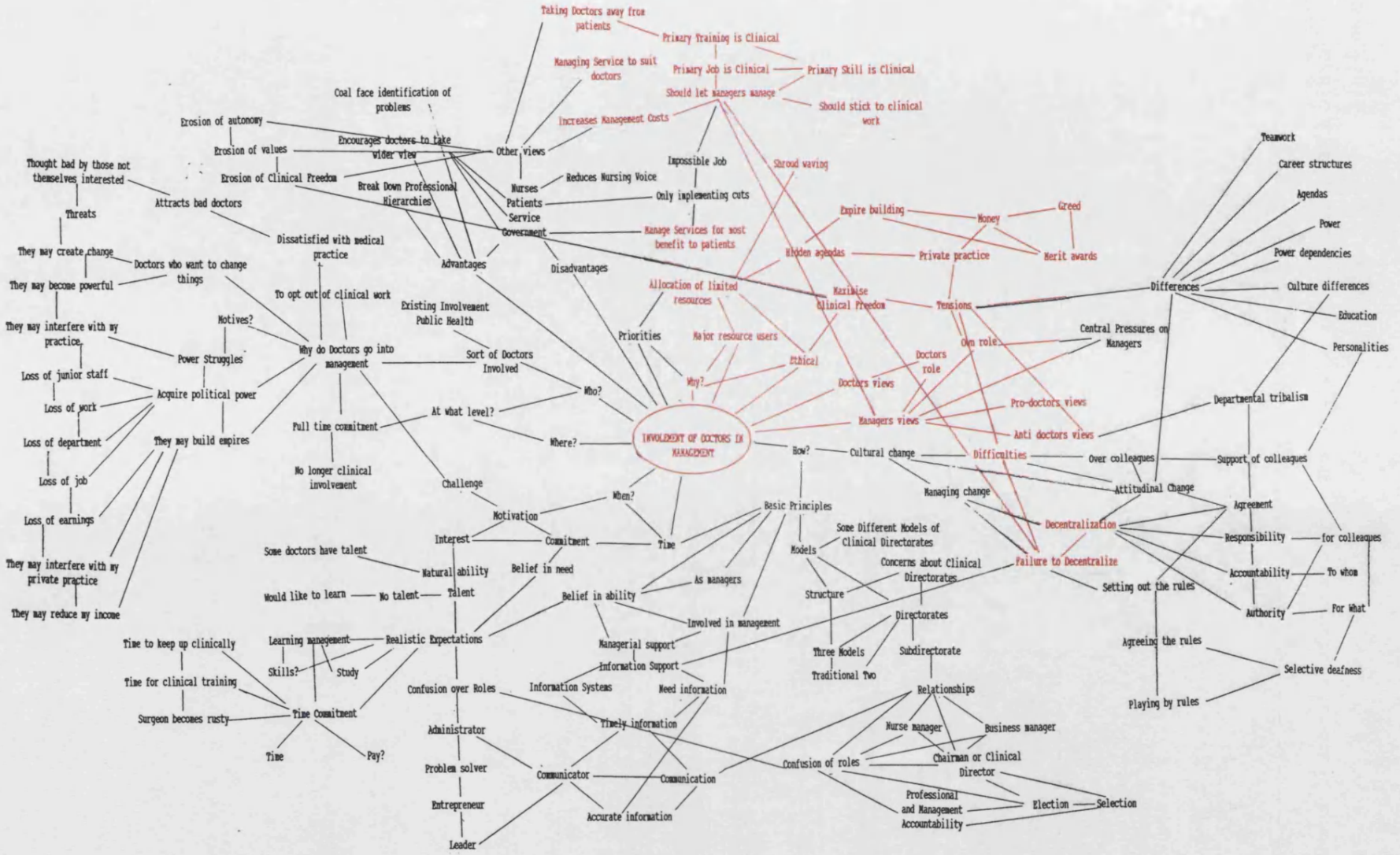
MANAGEMENT VIEW ON DOCTORS' ROLE IN MANAGEMENT

11.0. Introduction

Having in the previous chapter discussed some general aspects of involving doctors in management it is now appropriate to move into the next group of items that contain linkages with the items in Chapter 10. These are shown in the cognitive map on the next page (p.274). This chapter therefore covers the questions of both doctors' and managers' roles in management, as perceived by existing managers, and it reveals the tensions between the two groups. I will also discuss their view of the hidden and private agendas of private practice and money, departmental tribalism, and problems of working as teams.

11.1. Definitions

There can be some difficulty with an accepted definition of the word manager in the health service, as doctors, managers, nurses and other health care professionals are all now regarded as managers. "Lay manager" is regarded as a rather derogatory term for professional managers, and "non medically qualified managers" is not appropriate as some of the managers in this study did have medical qualifications. For the purposes of this thesis unless



COGNITIVE MAP CHAPTER 11
THE REASONS WHY IT IS IMPORTANT

otherwise indicated the term "manager" refers to both non medically qualified and medically qualified, professional full time (or virtually full time) managers.

11.2. The Traditional View

If the National Health Service was a pyramid then perched high on the apex would be consultants, a little above the general practitioners. They have to cope with the responsibility of managing disease for which each has been trained in the best of modern scientific medicine. Below them, towards the base of the pyramid, are a vast support staff aiding the work of the doctors, all serving medicine as in turn the doctors service each patient. Such is the scheme as seen by many managers, perhaps not so very different from the doctors' view.

West (1988:98) describes hospital management as the art of juggling and rationing the available services to meet the constant pressures from patients, doctors and other staff. As a UGM put it:

> "Medicine generates a constant demand for more services and equipment. Patients and staff generate all the hassles of large groups of people while the public at large expects more and more from the service."

There are the specialised managers of each component of the service, but they have especially in the past been

usually also competitors for resources not allies of the general managers of the hospital.

A Chief Executive talked about

> "Managers trying to reconcile competing pressures so that the hospital runs as well as possible while avoiding major conflicts and serious overspending."

Several managers described their roles as "all about balancing resources", trying to resolve conflicts in which they may have to find compromises which favour one vested interest over another. One UGM felt that

> "It may also be easier at times to do nothing about a problem particularly if focusing attention on it may lead to more expenditure."

A Chief Executive also gave the following example;

> "A problem was presented to the DGM who realized he had no money so he passed the problem down to the UGM to sort out. A way of delaying a decision. He had thrown it into another scenario. But the UGM could not make a decision because the only person who could release the money was the DGM."

Managers feel there is no need to look for work as there is usually so much being generated by all the different interest groups among the staff and by patient administration and complaints. Hospitals generate vast amounts of paper and data which must be organised into sensible statistics.

11.3. The Inability to Control

Managers generally feel powerless to manage because they feel that doctors are uncontrollable and do not understand the complexity of managing a hospital. Overspending is possible because the power to spend money is not solely in the managers' hands. Pharmacies may overspend because of a change in drug prices or the type of drug used by doctors. Nursing may overspend because of the need for sickness cover or a change in patients' patterns of care. Laboratories may overspend because of additional night calls for tests by doctors. None of these can be directly controlled by the managers and not every change can be budgeted for at the start of the financial year. It is difficult at times to get staff to face up to financial problems. Some cost items, notably drugs and disposables, increase with the amount of work done.

Managers recognize that their thinking process may be different from doctors but generally also feel the NHS "lacks management". One UGM said:

> "Doctors' thinking process is so different from managers'. I really don't think that doctors appreciate the complexity of the management problem or how undermanaged the NHS as an organization is."

Another CE:

> "Consultants have to be aware of the complexity of decision making."

There was some support for this from a Public Health Physician:

> "I think a greater understanding of what it is that managers do and their approach to the health service will help doctors increase their respect for and their desire for knowledge of those techniques."

However, whatever the complexity of the management processes, the formal management arrangement in the NHS is that managers are usually seen, by both sides, as negotiating with consultants and not handing down decisions.

11.4. How Managers See Their Role

A manager's views on the new NHS cannot be understood without careful consideration of what went before. When the NHS was created in 1948 administrators were faced with the power of the medical profession. Managers feel that many of the problems are because of a failure to establish a proper management structure and an integrated corporate culture.

There are also certain unique characteristics of any health care organization. These are mostly related to

some of the concepts of clinical freedom discussed in Chapters 5 and 6. I have described how in the 1974 reorganization, faced with the power of medical profession, a different tack was tried. If consultants could not be ordered to do things, it was argued that perhaps they might join a team. Consensus management was, therefore, the slogan that characterized that reorganization. An attempt was to be made to manage the health service, but its management was to be conducted by a group of equals, a group of fellow professionals.

Consensus management proved fundamentally unrealistic or perhaps merely went out of fashion. Managing change was difficult in the NHS. Layer upon layer of consultation was needed. Although such tendencies had been inherent from the beginning of the NHS, they were reinforced by the 1974 reorganization. Every interest at every level was built into the formal structure of the organization. Yet in spite of all this the clinical services themselves remained largely unmanaged. Also consensus management was not always felt to be a negotiation between equals. Some felt that the issue of the power of the medical profession had not been addressed. One manager explained:

> "Tribalism in the NHS is very strong; there are many but the two most significant are the medical tribe, which is extremely powerful, and the nursing tribe which is very large."

11.5. Are Doctors Unmanagable?

Tribalism is a term often used by general managers, referring to characteristic features of the health service professional groups, particularly doctors. Their differing cultures, histories and organizations, the huge fragmentation of the organization with so many groups, each with its fierce internal loyalties, appeared to lead to a lack of any external vision or overall control. The difficulty was that despite the commitment of everyone to the patient, in trying to provide an effective, coordinated overall service, doctors, it appeared to managers, pushed forward only the boundaries of their practice and departmnent and simply refused to be managed.

While the 1974 reorganization might have resulted in a new class of medical administrators or medical managers, the community physicians, as discussed in the previous chapter, were simply advisers and planners, despised by many of their colleagues and with no control over the consultants. In short, the NHS still took a most peculiar form (Short and Robinson 1990):

> "a giant state organization which was controlled simultaneously both by Whitehall and by thirty thousand doctors."

In 1948 the whole profession had been granted powers of unlimited clinical freedom the like of which many of its members had previously only dreamed. In 1974 nothing had been done to confront this individual medical power.

The power of the medical profession also meant that little information was gathered on individual medical activity. And what information there was could hardy be used for fear of what doctors might say. The contrast with the United States was instructive. There the macro-system was a mess. American health care was widely separated into large numbers of purchasers, vast, hugely expensive, sometimes shockingly unfair and unmanaged, at least at the national level. But in some local matters, there were real achievements to note. Given their very different powers over doctors and the systematic information on individual activity that a fee for service system provided, American hospitals had begun to pioneer new methods for medical micro-management; methods which were the envy of the lowly administrators within the NHS.

11.6. General Management Begins

So there was a gradual end of consensus and the rise of general management. But, despite this, the core problem remained, that the NHS now had local managers, close to the clinicians and regularly reviewed by the tiers above,

but what could they do to actually manage? The Griffith Report (DHSS 1983) put the problem like this:

> "If Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge."

The crucial division between general practice and the hospital sector was also left untouched, a theme referred to in earlier chapters and to which I shall return at the end. In each tier, a single leader, a general manager, was installed. General managers, as their title suggested, would, it was thought, manage everyone. Whereas the old district administrators had simply chaired meetings of the management team, each general manager was to be a real boss, in charge of the doctors, the nurses, the other professionals, the treasurers and accountants, the personnel department, in effect everyone.

In short, managers thought that it was going to be the general managers, not the clinical professionals, who were now to decide on the division of work, the training, the structure and the organization needed, as well as appropriate individual performance. The old coalition of separate but equal professions was thought to be dead.

Managers felt that specialists, i.e. consultants, possessed a parochial rather than a global perspective.

DGM:

> "We need to widen the perspective of doctors, open their eyes to a greater vision. They are, so many of them, parochial and inward looking."

It was thought that only generalists, i.e. managers, could balance the clinical and the financial sides of things, integrate the doctors, the other professionals and the patients, and view the whole. It followed that the health service should not be ruled, as it had been in the past, by specialists in health care, by doctors and nurses, but by those trained in health service administration and management.

Strong and Robinson (1990) set out the managers' indictment of medical individualism and power. At a micro level, doctors would still be free to run things in the way that they wanted but the power of the medical profession had meant, so managers argued, that individualism reigned throughout the service. One UGM (who was a doctor himself) said:

> "It is almost impossible to get children to do what you want them to do. They are just like doctors."

Another UGM:

> "I am answerable to nearly a hundred doctors who are answerable to God, and many of them do not even accept that."

11.7. Medical Individualism

There was medical individualism exemplified in every type of decision made by doctors. There are wide ranges of variations in medical treatment decisions, variations which are a key topic in the management conferences which surrounded the introduction of Griffiths (1983).

Managers saw medical individualism equally evident in the distinctive way in which doctors' participation in management decision making was effected. Decisions by a medical committee might carry little weight with any individual doctor unless they were on the committee. The only way round this problem of representation was to include everyone of the advisory committee, but this had it own difficulties.

The managers also felt that not only did doctors lack interest in corporate decision making, but the consultants were often ignorant of management issues, unable to understand the new management proposals and unwilling to play any part in such matters.

In addition there was little sense of institutional responsibility among some doctors; some consultants were engaged in ruthless competition with one another for more power and resources. Indeed, this empire building and competition for clinical resources proceeded, almost regardless of any financial or institutional constraints. As one UGM put it:

> "Not having general or orthopaedic surgeons or some other powerful group for instance diverting resources that would be better deployed for say an extra radiologist or ophthalmologist which is what we really need."

There was clearly a lack of a clear common interest in hospitals. The physicians and surgeons, radiologists and pathologists, the anaesthetists and psychiatrists etc., all have their own plans and patients and few common interests. A Clinical Director:

> "At the M.E.C. the radiologists want another colleague, the surgeons want another general surgeon, the physicians want another endocrinologist and a cardiologist, but the anaesthetists say we must have another two anaesthetists. They all have a very convincing case but who can say what the hospital needs most?"

Many managers also argued that medical science and technological progress often generated vast costs, many of them potentially unnecessary. New, highly expensive techniques appeared in a largely random untested fashion in respect to cost effectiveness and outcomes, propelled

by a mixture of personal ambition, scientific interest and concern for patient welfare. A DGM:

> "Some departments have spent large sums on expensive equipment which has hardly been justified by the use it gets, often bought with charity donations, the upkeep then having to be taken over by the hospital."

Managers know how doctors affect managerial choices when they expand their operations and treatments without taking account of the resource implications. Doctors often change treatments or operations without even a thought for the effects on the hospital. A physician may suddenly change to a new and much more expensive treatment without any thought for its effect on the departmental finances or the consideration of warning those trying to balance the finances. A UGM:

> "The radiologists recently started using a new contrast medium, it was hugely more expensive. They never told anyone it just appeared as a dramatic sudden overspend in the budget. And there are similar stories with cardiology and paediatrics. No one appeared to have considered whether the costs were even justified."

The hospital may continue to stock up with a particular prosthesis when the surgeon will suddenly and without warning decide not to do that operation any more. A CE:

> "The orthopaedic surgeons suddenly started using a different prosthesis, and we were still ordering to keep up the stocks of the old sort. They didn't think to tell anyone."

I have already referred at the beginning of this chapter to the problem of a change in doctors' prescribing habits. Another CE:

> "We have had examples of new, very expensive drugs suddenly being used instead of the standard one; the drug bill has shot up tenfold for that particular department, and it has been months before we have been able to identify and isolate the problem. The doctors never thought to tell anyone what they were doing. I don't suppose they even thought through what they were doing."

Nursing overspends through the need for changes in cover or a change in patients' patterns of care as a result of doctors' changes in work patterns or types of work have also been highlighted as lack of doctors thinking through their actions. A Director of Nursing:

> "It took the nurses some weeks to fathom out what was going on and why the pattern of nursing had changed; then they discovered that it was because the surgeons had all swopped around their operating lists."

Laboratories overspend as a result of additional night calls for tests by doctors, often done to fit in with changes in other doctors' patterns of work. A CE:

> "The consultant had changed his ward round and was seeing the admissions for surgery in the evening; as a result patients were coming in later. The patients were happy enough but it resulted in the lab doing a lot more tests in the evening."

None of these can be directly controlled by the managers and not every change can be budgeted for at the start of

the financial year but if doctors were acting less as individuals and were more involved in the management processes then even if they were not controlled, at least the management might get warning of changes.

11.8. Personal Agendas

Managers often feel that a shift in clinical direction may owe more to personal interest than to the needs of the hospital. A DGM:

> "They go off on study leave or some conference and when they come back they've developed some new interest. Some surgeons are only interested in doing their particular thing, some operations that they are interested in. They forget there is a lot of routine work, we all have boring things to do. For myself large elements of the work are boring, large elements I dare say for an ENT Surgeon are boring and there does come a point when you need to make a change."

Or some say that private practice interferes with hospital activity, a DGM:

> "the whole negativeness problem was really bound up with private practice income. What comes over is that what matters first is private practice, and anything else can be arranged around that. Now that isn't necessarily a bad thing, it's just not a good thing if that dominates everything."

Managers find it frustrating that spontaneous actions by consultants can upset financial programmes for a unit, hospital or district. Managers therefore face the difficult task of getting doctors to accept that their

clinical freedom must be counterbalanced by an awareness of, and responsibility for, the effective management of resources.

This task is made more difficult by managers' lack of clinical knowledge, which makes them hesitate when discussing professional and technical standards and can make them feel vulnerable when issues are raised with doctors on quality improvement. As one ex UGM put it:

> "Managers find medical discussions direct and harsh to the point of sarcasm. On the other hand doctors find managers' conversations equivocal, facile and vague, and their thinking woolly."

11.9. Playing by the Rules

Managers feel that they try to be careful in taking clinical issues into account in both the short and long term, through formal and informal consultation. They feel that arrangements are made for clinicians to influence and participate in management decision making at all levels. There is however a major disharmony between management and financial planning, and clinical practice and developments. Both are of course legitimate but at times they seem incompatible. Again we see that doctors' individual power rested crucially on their monopoly of medical knowledge. A CEO:

> "There has to be much greater honesty and realism about priorities."

Such problems it appears are multiplied in medical schools. A CE of a University Teaching Hospital:

> "The technical and imperial attitudes of acute medicine increased dramatically in teaching districts."

University and medical school doctors often appeared to have very special powers. They not only dominated the old administration but they appeared more able to stand up to the new general management.

Thus the individualistic ethic of medicine allowed the most powerful individual clinicians to dominate service priorities. At the same time, although doctors might be in fierce competition with one another for resources, this was a game they played among themselves. A medically qualified ex UGM:

> "Faced with any outside challenge, they merely closed ranks. It was always highly effective."

For managers, the emphasis on the right of individual doctors to take their own decisions too often meant a tacit agreement to support colleagues whenever they could, simply because they were colleagues.

Given the enormous power of the medical profession in the eyes of the managers, many of the old health service administrators had, it was argued, simply given in.

However, even in the new era, managers felt that many consultants expected to be dealt with individually at the very highest level. Particularly they felt, as one DGM says,

> "That consultants tried to do deals with everyone, with treasurers over breakfast, with colleagues over lunch, with the chairmen at dinner, or even directly with managers. Moreover, the medical, self proclaimed right to go to the very top, the assumption that all managers, no matter how senior, were there to service them individually, still carries over even into the private sector."

11.10. The Central Influences on Managers

Managers also feel they suffer pressure from the centre, (Region and Government), to ensure that Regional and National priorities for care are met and that resources are used efficiently and effectively, while at the same time meeting all the local needs and the aspirations of consultants to provide increasingly expensive high technology medical care. In addition they suffer the frustrations of having to meet these responsibilities within tight financial constraints, changing population needs etc. As one CEO put it,

> "With limited resources people simply put off making decisions."

There seems little doubt that managers recognize that they have no direct control over the major user of resources i.e. the doctors, this division of

responsibility having been inbuilt in the health service. Williams (1985) states:

> "An unfortunate division of responsibility seems to have grown up whereby costs are the business of administrators and treasurers, while benefits are the business of doctors and nurses."

11.11. How Managers See Doctors

So far I have only considered the managers' views of doctors' managerial role, but how do they see doctors as a group? On the whole managers were not over enthusiastic about doctors, and because there were so many views which covered such a wide spectrum it is probably helpful to consider both ends of the spectrum individually and then present a balanced discussion in a third and separate section.

11.12. Managers Unsympathetic to Doctors

Doctors came in for a good deal of abuse from many managers. Some doctors, they argued, were selfish, egocentric, lazy, greedy and arrogant; as one CEO put it:

> "Previously being employed by Region, they had gone on study leave, and if that left us short they would say "tough luck". A lot of consultants, certainly some of the more senior, have found it incredibly difficult to come to terms with that [the recent changes], they suddenly find that they cannot just change around their programme because it suits them, they now have to talk to someone and almost get permission for that. The younger consultants have no problem with that concept."

One UGM said:

"I think consultants are lazy, I think consultants actually want to do less work, at least here. It is possible they want to go down the road more. [referring to a local private hospital]."

Consultants were seen as highly aggressive on their own account but always willing to cover up for each other, an issue already referred to when they close ranks. A DGM said:

"many doctors are too loyal to each other. They sit and listen to things that they know are wrong, things that they will come and tell you are wrong, but they do not have the bottle to stand up and say, this needs to be put right, and once you have gone through this for a long time it does tend to cause unnecessary loss of respect in terms of testing the motivation of clinicians".

Another DGM:

"The basic test is, that if you would not let your family be treated by that person, why do you sit quietly and protect that person and let everyone else do the same? So there is something about those collective values that I feel are quite negative and dishonest when placed against the backcloth of saying they want to do the best for the patients."

Also they are very parochial, or as one DGM put it:

"they are only interested in their own particular speciality."

In the view of a UGM now CEO,

"There is not enough corporacy to say, how do we provide better medical services here? You are all very good at saying how you provide very good medical services, but how can you improve the hospital.....go

and talk to an ENT Surgeon, very good at doing the ENT bit, but there is a reluctance to sort out, say, the terrible General Surgeons, who they meet every day on the corridors, and who are actually impinging on and impeding the service that your hospital provide. And managers are prevented from doing that."

11.13. Some Qualifications

Most managers feel that these views which they expressed applied to the characteristics of doctors as a group. At an individual level, many managers praised the doctors within their hospital. So, for all managers' fierce criticism of doctors, their comments were often balanced by some positive remarks, although I suspect that such remarks as,

"having said all that, they are good chaps really",

were an apology to me for what they had said. But most managers often took care to qualify their criticisms; many described doctors as very hard working, even workaholics, and some noted super workers who had loyalty to the institution or organization. So the complaints from managers were, for the most part not about the doctors' individual attributes but more about their properties as members of a profession. Moreover, even at the group level, their attributes vary. The doctors with joint appointments found colleagues in a non-teaching district far more reasonable than those in the teaching hospital.

Such views were held by many different sorts of manager, both with and without clinical backgrounds. So that although doctors might be slowly moving towards a more corporate view of things they remain, so it was argued, individualists at heart. That individualism might vary from one doctor and one institution to another, but the medical profession as a whole entity still, it seemed, blocked most attempts at corporate planning and allowed the minority to dictate to the majority.

Managers would like doctors to be able, as one DGM said,

> "to sit down and look at the impact of their activity on the total health care of the district and to get them to see their activities and the effects of those activities in the context of the broader view, the whole hospital or institution, even the whole district, and not just take a blinkered view of the problem in front of them."

From then it might be possible to make reasoned allocations of resources. Managers recognise that it is important to involve doctors more effectively in management although few expressed very clearly what that meant in detail or how that might be done. The desire was common however, the following being typical comments by managers:

> "To remove the barriers and mutual suspicions between doctors and managers. If we could both accept that even though doctors not unnaturally offer a different perspective to management, we could try and move the

organization in the same direction and all pull together."

"If we could get doctors to accept that managers need to match services to resources for the whole organization and understand what that actually means."

"To help and join with managers in making choices by the realization and acceptance that resources are limited."

Managers accept that doctors need to take a key part in management but by participation and compromise not by veto. Unfortunately not all managers share these views; as one extreme management view is that managers, as one DGM put it,

"Must curtail the excessive power of the doctors, curbing them in to ensure that district plans are achieved."

11.14. Managers Sympathetic to Doctors' Attitudes

On the other hand some managers see the medical profession as a powerful organization which should not be emasculated but carefully cultivated so that the doctors' skills, energies and intelligence are harnessed to tackle issues and even manage themselves more effectively, and to continue and increasingly to involve doctors in taking corporate decisions at district level, as opposed to them advising on decisions but not making them. These latter views are of course easier for managers within units and departments. But it is at the higher levels where it is

more important to manage the medical profession by enlisting the doctors' cooperation in management or encouraging them to work as managers. As one DGM put it:

> "A lot of managers do not like to admit that they [the doctors] are important, but I see them as by far the most important set of people, potentially, either for good or for ill. If you do not have the consultants wanting to go in a particular direction, then the hospital or the health service is lost. And whether you think you should be a manager who should control them, or support them in the old fashioned administrator sense, as I was taught, (we were the "oiling the wheels" men if you like, would bow down to what the surgeon wanted and help him get there), that subservient role or right through the spectrum to I'm the manager and I'm going to tell you what to do. Whichever way, it seems to me, unless you actually are either subservient to getting them to do what you want, or as a manager to do what you want, the hospital is not going to do the right things."

Another CEO (not medically qualified himself) put it like this:

> "I see them as the most important group and a lot of people do not like that, and lot of people do not believe it, and a lot of doctors do not believe it themselves these days. They do not feel they argue with any credibility or importance. A lot of managers do not like to admit that they are important, but I see them as by far the most important group."

Some managers recognised the different aspects to the relationship, and also how it might vary between different types of hospital and with different doctors. As the Chief Operating Officer and Vice President of a U.S. teaching hospital put it, the relationship was

> "Positive, comfortable, strained, angry. I think the strain has to do with finances, availability of staff,

equipment, opportunity to develop new and interesting programmes. My background is all large private community teaching hospitals, not state institutions, and there is a big difference between the two. Doctors in the private institutions understand referral relationships, communication, seeing patients, clinical excellence, working relationships with other colleagues; in this particular institution, I find less of that."

11.15. Discussion

Not surprisingly managers show elements of all views, as was demonstrated in the last quote from North America, although varying in relative proportions not necessarily in relationship to their training or background but perhaps related to their management style and the problems they face and the characteristics of the doctors with whom they work. There has long been a stereotyped view of how managers regard doctors. One academic in health care management put it thus:

"There has been a long and dishonourable tradition of mistrust between managers and doctors, which is not surprising since whatever the particular organizational forms that we use at any one time, basically the managers have the money and the doctors do the work, or at least do things to patients. That introduces a very interesting and necessarily tense relationship between the two sides. The question therefore becomes how to mediate that relationship best, so that it is for the mutual benefit of both."

To some managers the problems are seen as creating opportunities:

"To enable this hospital to be more than it is, to put into the balance, both the needs of the clinicians, the research staff, etc., to provide appropriate management

so that we would have resources, both financial and people, to make sure that we survive the twentieth century into the twenty-first century.

Our location is a problem to us, and we have to change the way we relate to people, because there are plenty of other locations, health care centres, medical centres, hospitals, clinics for patients to go to. If we don't treat people as they should appropriately be treated, then one day they'll go somewhere else."

Others recognised that in the past they had not competed for resources. Now they have to cope with that, as a CEO said:

"Finances are a constant problem; health care is becoming increasingly day case orientated, there is less demand for beds, and hospitals are going to get smaller or close."

Managers felt that they had been too concerned with running hospitals on a day to day basis rather than taking a strategic long term look. This had not been helped by the relationship between doctors and managers:

"I think we may have taken ourselves [the hospital] for granted. What we have to do is create, access and service, make sure our staffing is good, that we have the necessary equipment and services. That will then allow us to compete in a larger geographic area."

Involving doctors in these strategic management processes was seen by some as an essential prerequisite of this process:

"There are a few hospitals where a clearer management line has reached the technical and professional areas and they have become involved in strategic planning."

11.16. Management and Decision making in the NHS

Before leaving the question of managers I would like to introduce the role of management in the decision making process within the NHS. Klein (1985), asking the question, who makes decisions in the NHS, feels that the National Heath Service is a remarkable organization because almost everyone working in it - whether as a doctor or as a nurse, as an administrator or as a ward orderly - is a decision maker. He says:

> "It is precisely this proliferation and pervasiveness of decision making that makes any attempt to anatomise the process - to identify with precision who is responsible for what - so frustrating and baffling."

The large number of separate decision makers in the various professional groups is what would most separate health care from industrial and service industries. To look at management in more detail it is necessary to separate the management and decision making process into operational management, the day to day running of hospitals and related services, from strategic management where the big decisions will affect the service over years rather than days. I have already referred in previous sections to at least 60% and perhaps up to 80% of the costs in hospital being the result of doctors' orders.

11.17. Operational and Strategic Management

Operational management is generally thought to be the preserve of the junior managers, the clinical and support services managers, and strategic management the responsibility of the General Manager or Chief Executive Officer. One manager, a DGM put it like this:

> "I do not see my job as taking decisions; my job is to make sure that decisions are taken with the appropriate people engaged in that process to get the best decision. An important part in all this is involving the right people to provide the right advice to establish all of those things."

And finally, strategic decisions are the preserve of the Health Authorities or the Trust Boards. The issue for some managers seems to be the threat of Clinical Directors to their own control and authority. One manager a CEO put it like this:

> "I would like to ask, what problems do the consultants actually need to be involved in? Consultants have to accept that in the management structure their work process entirely is day to day although psychologically they believe they are much higher."

However US managers feel somewhat differently. A President said:

> "Clinical Chairmen have a great amount of influence as well in any planning and resource allocation and deployment mode."

Another U.S. Hospital has a planning retreat every year where all twenty members of their Medical Executive Committee participate in providing strategic planning to the hospital. The Chief Executive Officer includes Clinical Directors in their discussions, regarding budgeting and planning activities.

11.18. Winning Over the Doctors

American managers from Johns Hopkins Medical School emphasized the necessity of winning medical consent but recognised the power in some hospitals to sanction recalcitrant doctors by terminating their contract. A U.S. CEO explained:

> "All our doctors are on two year contracts although we would give them a year's notice if we wanted to get rid of them. The Chief of Service (a doctor) carried a lot more clout than anyone comparable in the NHS. He is appointed by the Dean and the Director".

At Johns Hopkins itself and many other academic centres however, many of the medical staff hold academic appointments and are less easily controlled by the hospital.

However, there has been a big cultural change of heart in the last few years. Most of the chiefs of service are now very management oriented and very responsible; they are data oriented, noting for instance if a doctor's

length of stay for in-patients is grossly abnormal. As a result of the changes in approach a lot of the old chiefs left, unable to cope with the changes. They didn't like the management style. The newer ones do, and work well with the system.

In Britain however, given doctors' lifetime contracts and the power of the medical profession, it has been almost impossible for managers to remove them. It could just be done, but only in the most damning of circumstances, and it would take many years of struggle and extraordinary effort so that it has rarely even been attempted.

11.19. Hospital Management Generally

West (1988a) considers that the actual control of hospital managers is different from that of managers in other organizations. This is because managers must liaise with various professional groups and coordinate activities from outside. However, one manager felt that his perceived success was because he was from outside the National Health Service. He said:

> "I have been relatively successful here because I am not an administrative professional."

Managers on the whole felt that the impact of the Griffiths Report in 1983 was limited because of the key role of the professional staff who had not become more

involved in management. Although this is an issue that I will discuss in my conclusions, it seems appropriate to give the managers' views for this now. Managers feel they are trying to reconcile competing economic and resource pressures so that the hospital runs as well as possible, while at the same time avoiding major conflicts and serious overspending. To resolve conflicts in operational management they feel they often have to find compromises which favour one vested interest over another, so that it may be easier at times to do nothing about a problem, particularly if focusing attention on it may lead to more expenditure.

It is also worth noting the style of management in the National Health Service. Because so much of the senior management task is negotiation with key groups rather than day to day control of individual departments managers spend most of their time in meetings and much less time at the grass roots where many of the problems arise. One medically qualified UGM felt that his small residual clinical commitment was an advantage in allowing him to go into the wards, the outpatients and theatres and see and get a feel of the atmosphere of what was happening. He added:

> "Courses on Medicine for Managers are no substitute for going into the hospital, and managers spend too much time in their offices."

They would argue that there is usually so much work being generated by all the different interest groups among the staff and by patient administration and complaints that there is no need to look for work, and walking around the hospital seems low on a managers' agenda by comparison. Carlson (1982) refers to this as "Visible Management" and "MBWA - Management By Walking About". Hospitals generate vast amounts of paper or computerised data which must be organised into sensible statistics. Medicine generates constant demands for more clinical services and equipment. Patients and staff generate all the hassles of large groups of people while the public expects more and more from the service. However a health care academic who had been an experienced UGM and DGM admitted:

> "The reality of having to go into the changing room or into the theatre or clinic to meet a surgeon is still daunting for most managers today I think. The fact that you've got lots of younger ones, and they're changing makes it even more difficult for them."

He felt that managers have always subconsciously felt subservient and inferior to the doctors:

> "We were very subservient to the medical profession, who were very powerful and I think many of us who were trained in that era still have that reverence, fear, antagonism, shown in different ways, to the medical profession. That is sometimes why people want to manage it, to sack them, that sort of attitude, it stems from an inferiority complex. Managers are usually much less well educated, whereas most medical people coming in recent years have had a very high standard of education. So I think the relationship between the two, was that we were traditionally rather

> afraid of the medical profession. And that still exists today, even though there's all this macho management talk."

And in America there is this same feeling, as one Chief Operating Officer put it:

> "I truly think that the adjectives that they [the doctors] would use are removed, distant, and in many cases not terribly bright. I think some physicians feel that some hospital administrators are frustrated physicians and couldn't get into, or complete, medical school."

11.20. Conclusions

To summarize I have discussed the topics brought out by managers about how they see their own role in management of the hospital clinical activity, and how they feel about doctors being more involved, as well as their feelings for doctors as a professional group. In each area I have identified specific issues which often result in tension. In the next chapter I propose to show the results of investigating those relations in more depth.

CHAPTER 12

THE RELATIONSHIP TESTS

12.0 The Tests.

During the course of considering the results of the first few interviews my attention was drawn by my wife, a trained Relate counsellor, to a technique they use for seeking the true feelings about relationships by using stones to represent individuals, and asking clients to place them in relation to each other and explaining why they have done this.

I therefore decided to experiment with this technique (Skynner, 1976) and began with two discs, one representing the medical profession and the other the managers/administrators. I then refined it by asking them to place the two discs not only in relation to one another but also in relation to the hospital, represented by a sheet of paper or card. This forms the basis of the first test - the two group and hospital test.

12.1.0. The Two Group and Hospital Test

The relationship of the Doctor and Manager to the Hospital.

12.1.1. U.K. Doctors.

The doctors generally acknowledged the central role of managers in the organization. One doctor who had experience of being a Clinical Director and a Unit General Manager who was insistent that they still be called administrators, said:

> "Administrators are firmly in the hospital; you cannot run the hospital, without skilled administration. You cannot leave any organization to run itself with its operational management."

About three quarters of those interviewed felt that managers and doctors were working together within the institution. Typical of the responses of Clinical Directors are:

> "They are both serving the patients and responsible for the patients, which is then fronted by the medical profession. What this is suggesting [referring to the position of the discs on the card], is that the management are there to back the medical profession who are there to deal with the patients, but you could equally well say that the management are there to provide an environment and a service, in which the medical profession is just one of the things that patients need, also needing nurses and catering."

> "There should be a shared set of values, aims and aspirations and the more the different interest groups, and in some cases pressure groups, can communicate and share those values and standards, the better for everybody and certainly for the people it's supposed to be about."

Some of the doctors felt that although working together, they were both partly marginal to the hospital but for different reasons:

> "The medical profession has its professional authority outside of the hospital and the management and administrators have the need to manage the external environment, so both must spend some of their time looking outside to see what is going on."

and some felt that they were working in different directions:

> "I think the biggest problem is the money. We have the problem where the management think they have to go out and look for patients in order to get more money, and we feel we have more than enough patients anyway. They want us to try and treat patients who will generate funds and we say we decide what we are going to do purely on clinical grounds."

The remaining quarter were equally divided between those who felt that the doctors were marginal to the hospital, those that felt the managers were marginal to the hospital and even those who felt the managers were not truly part of the hospital but imposed from outside.

12.1.2. U.K. Managers

The managers were much more unanimous than the doctors. Managers were working together, within the hospital as an institution, but their language was less assured, and they were less able to verbalise the reasons for their choice:

"Discs should be on top of each other within the hospital, no order, no particular reason."

"Overlapping within the hospital, because their interests need to overlap."

"I've put the management and the medical profession at the same level, because I don't think either can, or should, dominate the other."

12.1.3. U.S. Doctors

Here again the majority view was that the administrator and the doctor were both working together:

"Both inside, we have to be partners or we aren't going to get it done."

"Well I mean my job depends on both of them being inside."

Again some of the doctors saw the two groups both having roles inside and outside the institution:

"I see both of them straddling the edge."

The doctors felt that the medical profession were on the edge of the institution, more outside than in. About a third of doctors felt that the doctors were entirely outside the hospital as an institution and they were as much customers of the hospital as the patient. About half felt that they were just about outside the hospital.

In a sense this feeing was reflected in the answer given by one doctor:

> "Physicians, one third into the hospital, and two thirds out, in the sense that their activities are so oriented to non hospital affairs now."

Some recognized that some doctors were inside and some outside:

> "Definitely the administration inside the hospital; they do take their job seriously whatever else you may say about them, they do want to see the hospital succeed in all its missions, but doctors, some are in and some are out."

However, the majority view was that although the administrator and the doctor were both working together the doctors were primarily outside:

> "I see the administrators as primarily in the hospital, but to some degree they're also outside administering it."

> "I think physicians are primarily outside the hospital, but that's a perspective from the Department of Medicine."

> "I think the physicians would be more outside the entity and the administrators more inside the entity."

These differing views have already been referred to in the different way in which American medicine, based on private fee for service, with the doctor being a customer of the hospital, compares to the U.K. cost limited service:

"I would have to say that if you go across to the most successful hospital in town, that's xxxxx Hospital, that's a private hospital, in that you have the administration inside and the medical profession outside. It is a business, they contract with the physicians, and they need those physicians."

But some doctors recognized that things were changing;

"I think management would have to be effectively inside the hospital, but there is a way that it is going to be changing. And the reason it is going to be changing is the concept of joint ventures which may be something you are not familiar with. A joint venture would be say, that the hospital and the medical staff would go out to the market place and set up some type of managed care proposal."

12.1.4. U.S. Managers

No difference in response to their UK counterparts, but more positive and willing to elaborate:

"Both inside. They have a common agenda. There may be conflict, that is natural, but there must be a balance."

"This hospital is largely administrator driven, although we do have a physician Head. But the idea of running a business with the doctors outside of it, relating to us in a We/They fashion, is not nearly as attractive as being in partnership."

"The doctors generally are very grateful for help and if you are really interested in helping them achieve their objectives their loyalty to you is incredible, and the relationship can be very rewarding. So we're in it together."

"If you are working for a hospital that has a mission which is not consistent with the mission of the physicians, then you can easily get crossed-wires and

in many ways be adversaries, although some people say it's essential we have an adversarial relationship, because that is a check and balance kind of thing. So I would say we work at it together"

"I don't think I can exist outside the organization so for my perspective the administrator is always inside with the physicians."

As in the UK there were a few who did not wish to elaborate:

"Both inside."

"In our system, both inside."

12.1.5. Comments

I have already mentioned in Chapter 13 section 6 the question of those influences outside the hospital which impinge on the working of both consultants and managers. Although in the answers and discussions both doctors and managers acknowledged that doctors have need to be partly outside the hospital; some now saw the need for managers to work outside too. Some U.K. academics who had been managers did agree that this was important:

"Management needs to be more outside the hospital because they are, more than most doctors, concerned about the boundaries between the hospital as an organisation and the rest of the health service, the public, the politicians and society at large. So I see them half in half out of the hospital. I see the medical profession as mostly in, because most of their energy and attention are focused inside, but with a significant piece outside, but a little less than the amount for the managers."

Others thought it would be beneficial for the service as a whole for the doctors to be more detached from the hospital:

> "I'd like to see more of the medical profession uncoupling from the hospital as an institution and seeing things in a more holistic way. You see it in some specialties already; paediatrics for example, has largely managed, mentally to disassociate itself from the hospital and see the whole of the delivery of service for children as being something that's not the be all and end all in the hospital.
>
> On the other hand, most surgeons it seems to me, take the view that there is a hospital, and there is this boring bit outside which we throw the patients back into, and they don't want to know about. Maybe that is a caricature, but not a wholly unfair one."

12.2.0. The Relationship Test

The second test consisted of asking about the doctor, manager and patient relationship to each other. This project is not about the doctor patient relationship but I thought it might be interesting and instructive to consider whether, by deliberately introducing this third party into the test, it might have an effect on the outcome of the findings. The second test was therefore for the participants to relate the three, the patient, the doctor and the manager/administrator, to each other, and explain the reasons.

12.2.1. U.K. Doctors

Three quarters regard the three groups as equal partners;

> "Three discs overlapping equally. The doctors and the managers there to serve the patients."

The only thing they felt unsure about was how much of an overlap. The work that doctors do in a hospital is to a large extent obviously not part of operational management, and similarly the work of management is not medical, but they see an area of joint responsibility for the processes and systems within the hospital.

Doctors spend a lot of their time relating to the patients, but patients' interests are partly different from doctors' and managers'; the perceptions of patients of what health is and what they want out of it, are not necessarily congruent with what the professionals within the organisation think. Patients often value things differently from the way professionals value things. I was given two separate examples expressed by doctors:

> "Maternity care, where there is a good consensus with doctors and managers that people should have their babies in hospital, but actually there was a significant patient resistance to this and not because they were ignorant, but because women genuinely were prepared to take the risks, because of their perceived benefits."

> "Aids patients have demanded a type of care that would not have naturally arisen from within the organisation."

The majority felt that all doctors were managers now and that everyone was ultimately there for the benefit of the patient. A typical view was:

> "To me we are all managers. On top is the patient, because that is the product of what we are trying to do, and what this is meant to represent is that all other professions are working together to serve the patient."

But a fifth felt that the doctor stood between the manager and the patient. This view was expressed as a feeling that the hospital was increasingly being run to balance the books rather than to serve the needs of the community, and that only doctors were fighting for the needs of the patient:

> "Increasingly the pressure is to operate on patients for money. If they are patients of a GP Fund Holder they come in next week. If their GP is not a Fund Holder they are placed on a waiting list for a year or more, even though they may be clinically more urgent."

12.2.2. U.K. Managers

The UK Managers were less enthusiastic about an equal relationship between the three groups, only a half seeing them as equal. But again they did not seem willing or able to express reasons:

> "I think, something like that. I don't know why."

> "Just like that. No reason."

A third put the managers and doctors together on top of an inverted triangle;

> "I put patient under there because I usually think of it from the perspective of managers, and also of the medical profession. You could I suppose also have patients on top, supported by managers and medical profession, but I would prefer it this way."

12.2.3. U.S. Doctors

Here again like their U.K. counterparts three quarters of those doctors interviewed expressed a view that the relationship was equal:

> "I have to put them in an equal triangle, which is probably the least helpful answer you can get. What actually happens is that the management if you like, tries to provide services which patients are coming to receive, and the medical profession, in this hospital at least, partly work here to provide patient care but also to do other things as well, and they don't really run this relationship very much."

> "In terms of the ideal situation you would tie them in as an over-lapping area, because management must be responsive to the demands of the patient and the demands of medical profession. For example if the hospital was very dumpy, in a lousy area, patients just won't come, if the hospital makes it extremely difficult for physicians to get work done, then the physicians will just not come."

> "I think they all have to be inter related; the hospital administrator must be as concerned about the patient care as he is about the physicians delivering patient care. The patient must be aware that the hospital does not have a printing press in the basement and is printing out dollars and can do anything for free."

"I think there has to be an inter-relationship and I think they have to be an inter-relationship of equals, not that the doctors are over the other, that this has got to be a team approach. No longer can the physicians do it alone."

Although the difference here was that about a fifth saw the administrator intervening between the doctor and patient, rather than as in the U.K. where the doctor came between the patient and manager):

"They are between the physician and the patient, facilitating the physicians work. Their job is to see that the essential relationship between patient and physician works, to provide and facilitate whatever is necessary for that."

12.2.4. U.S. Managers

Again exactly half of the US administrators saw the relationship as equal just as the UK managers had done. But again they were more forthcoming, thoughtful and thought provoking:

"Basically equal, and changing that would be difficult to do."

"All three pretty much equal. From the perspective of management these [patients and doctors] are our two biggest client groups, the patients being the biggest, but the medical staff being equally important, they're just smaller in numbers."

The difference was the third who felt that the administrator separated the doctor from the patient,

rather than as in the UK group where the managers saw the doctor coming between the manager and the patient:

> "I would like them still to be between the doctors and the patients, but facilitating; I think their role is to see that relationship between the patient and the physician works well. The administrators should be almost invisible, but doing a great job."

12.3. Discussion

Some of the participants were unable to grasp the concept of what I was trying to achieve, possibly because of my poor explanation, but mostly the idea was quickly and rapidly grasped. On the whole those who did so gave considerable thought to positioning the discs, reflecting and changing them, sometimes thinking aloud as they did so;

> "It's been a long time since I thought about anything like this. How I'd like it to be. The patients are hardest to put into the equation, I don't quite know what to do with the patients."

A few were hostile or dismissive. One Clinical Director said as I laid the discs on the table:

> C.D: "I see no reason to change what you have set out.
>
> A.W: You are entirely happy with that?
>
> C.D: I'd like them to be in alphabetical order, they appear to be in reverse alphabetical order.
>
> A.W: Why would you put them in alphabetical order?
>
> C.D: Because that's the conventional collating sequence for literal strength. P. M. A. In the conventional

alphabetical sequence it would be sorted on the first letter."

Another manager literally threw the patient disc to the corner of the room saying:

"Patients are not involved in this relationship. It is all about doctors and managers."

It was only later that I discovered how accurate this remark turned out to be about the relationship between doctors and managers. The question I did not ask directly but which I was later to observe from the results of, and explanations given for, the two tests, was, how were managers and doctors seeing each other in relation to each other? In other words, was what they were doing fitting with what they were saying, and what was more important and meaningful, was what they had told me during the previous hour or so of interview fitting in with the information I was now obtaining from them? Although I had not planned it as such, it turned out to be another validation.

It was here that I encountered some interesting findings. I have discussed power struggles in a section in Chapter 13.2, where I showed doctors think the balance of power has tipped in favour of managers, doctors and managers see an increase in the managerial control of doctors' work, and doctors fear they are being removed further from decision making.

I have quoted Strong and Robinson (1990) who feel that this is a worldwide phenomenon, whereas others like Chantler (19910, (1992a) and Griffith (1991), (1991b) and (1992) have put a different interpretation on things. Does this further information support these impressions?

Of the U.K. doctors interviewed only a tenth see the managers as in control, and seventy percent see themselves on an equal footing with managers. Indeed all the managers see themselves equal with the doctors in the control of the hospital. Now it may be that this is a change from a previous position, but those who discussed the situation as it was, the present situation, and the likely future change, did not see managers increasing their power and influence as seemed the popular theory. This would fit the idea of Charlwood (1992) who feels that many managers are beginning to feel uncertain about their future.

This is a situation where half the doctors and half the managers demonstrate that it is the doctor who is dominant in the management of the strategy of the hospital, the decision making processes and how it changes. A doctor put it thus:

> "I can't imagine how I could possibly put the administrators on an equal plane with us. You know if they are doing well and the hospital's making money and we have all the latest equipment and there is no

problem about getting some new toy that is really necessary and if you can justify it. No I have no problems at all about that arrangement."

Two administrators summed it up:

"This is a doctor driven institution, no question about that and the administrators are here together to serve the doctors and patients."

"I think management and administration need to support these groups. We need to find ways to help doctors work better and smarter."

The remainder seem equally divided, whether it is a partnership of equals or whether the managers determine priorities of strategy. Now this is partly through the diverse nature of the American hospitals, the driving forces being somewhat different for University Hospitals, Private Hospitals, Community Hospitals, County Hospitals, Religious Not for Profit Hospitals, Veterans Hospitals etc., but my investigation included representatives from each type. Those interviewed suggested no dominant change of the balance of power in favour of managers. On the other hand maybe they had never really thought about it in depth before. A Clinical Director said:

"I have a hard time deciding whether to put administrators over the medical profession or next to them or below them. They're really not our direct bosses, although to a certain extent they are, depending on what we are talking about. But they are more likely to work with us. We have a great majority of effect over the patients and they have some effect, but very little. I am happy with this, but as I look at it more, perhaps it should be different. Therefore the administrators are in reality having more influence on patient activities than I prefer and therefore it

may be in reality that they have a lot more influence than I like to think or prefer and I would much prefer to have them alongside us and let us have, as the medical profession, most of the influence, not all of it."

This U.S. view by both parties to the dominant role of the doctors leads to an acknowledgement by administrators that their supportive role still needs to take account of financial constraints. One administrator said:

"My view of management administration is that we need to be facilitators to accomplish the best that we can for these groups within whatever financial reality that we have to deal with."

Another administrator put it like this:

"So I see administrators as the bottom of the pyramid trying to be the support for these groups and that if you then say, what about the medical profession, well patients, are probably up here a little bit, I believe that doctors have to always be advocates for their patients. That in any decision that costs money, I always ask the people that advise me, get involved, look at all the issues, tell me what needs to be done for this patient. Is it reasonable to consider transplanting a liver in this patient, if it's really reasonable in this patient, not just a last ditch effort in which we're throwing money down the drain, then it's my job to try to find the money to get you the liver transplant. But you've got to really consider things, because you've got to realise that if we spend $100,000 on a liver transplant that's a $100,000 I don't have to give you for something else. But if it's necessary for this patient, we all have to do it, it's our job as administrators to do it, we'll try to make up the $100,000 some place else, by being more careful etc."

One of the doctors recognized that the administrators may have a dual role:

"I think it is appropriate for the management and administrators to support the ability of the physicians

to care for the patients. But it is also the responsibility of the management to make sure that that is done appropriately well and with the appropriate cost controls. So I see the managers being underneath and above."

12.4. Future Developments

This part of the discussion with the participants often led naturally to a consideration by them as to how they saw the current changes developing in the future, as there was total agreement that things were changing.

Many participants, both doctors and managers, commented that the patient was being removed more and more from choice in health care; although that in itself is not part of this study it does reflect on the possibility of doctors having less control in the management and decision making processes in hospital care. A U.S. doctor said:

"But I truly think that the major issue here is that patients are going to be further and further removed from their choice of health care, because as managed care becomes a larger and larger payer, these people's choices virtually disappear, and I actually think you should begin to have a fourth circle - insurance."

On the other hand some doctors feel that the patient is generally not sophisticated enough to make the choice:

"I think part of the trick, in this non trick question, is really that patients should be the drivers and that's really very hard to do and that's a problem on both sides of the Atlantic. We delude ourselves here that private medical care, third party funding and all

the rest of it for patients, allows them to choose the kind of health care they receive and they have greater flexibility, to seek out what is excellent and therefore by free market economy type mechanisms, the patients really do get what they want and I just don't think that happens. And I don't think it really can happen. I think it should be that patients' needs are addressed from the patients' perspective more than they are, but I don't think the patients will ever be sophisticated enough to do that without the medical profession and probably professional hospital management people doing it for them."

There is agreement that doctors should be, are on the whole trying to be, and are needed to be, more involved in management. A manager typifies this attitude:

"We're trying to get more of the doctors involved in making decisions that says there's not an unlimited amount of money, we all have to use what we have and use resources in the most thoughtful way."

One manager saw the manager and doctor merging into one professional group. Although others saw whatever the background of the person who acted as the manager, they would then become gatekeepers. The issue worldwide is that resources are not limitless, and to do the best for the most the response of this Clinical Director sums up many doctors views:

"I regard my involvement in management as an extension of my clinical freedom, and I think it would now be unethical not to do so."

CHAPTER 13

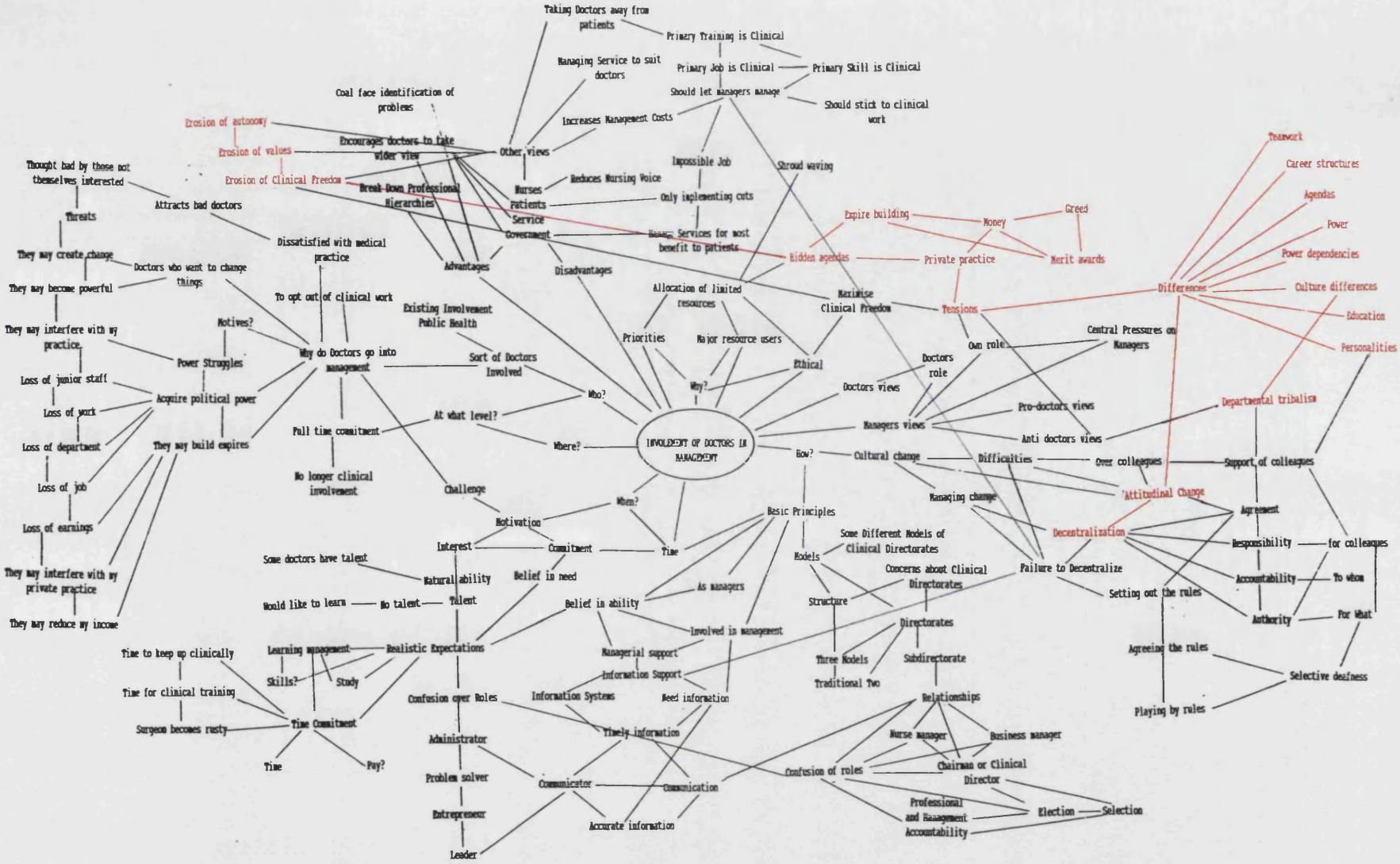
THE DYNAMICS OF THE DOCTORS' MANAGEMENT EXPERIENCE

13.0. Introduction

In this chapter I will explore some of the factors which make up the tensions for doctors in management roles and between doctors and managers, including differences in - career structures, agendas, power bases and power dependencies, education, autonomy (clinical freedom), values etc.

13.1. Clinical Freedom

The medical profession was given a distinctive position within the NHS when it was founded stemming from special characteristics acquired by British medicine over the previous two centuries. Before the formation of the NHS hospital doctors had fallen into two main groups. The most prestigious and the elite worked in the "voluntary" hospitals, which had largely originated as eighteenth century charities. These hospitals were governed by Boards of Trustees, but there was no overall person in charge of the doctors and the medical staff held enormous, independent power.



COGNITIVE MAP CHAPTER 13
WHY THERE ARE TENSIONS AND THE DIFFERENT CAUSES

Their colleagues in municipal hospitals however, much the larger group of hospital doctors, were in a very different position. Their services were controlled by local politicians and, more immediately, by a doctor who was also a manager who had very considerable powers, the Medical Officer of Health.

Although all consultants within the NHS are paid a salary, they have been managed on the voluntary not the municipal model. Thus, until the formation of independent trust hospitals, no hospital doctor had an overall boss and no doctor had a manager. The privileges of the elite had been extended throughout the whole sector. No hospital doctor needed to accede to local politicians or to a Medical Officer of Health. Although the NHS claims considerable power over the profession as a whole, it appears that its ability to control individual doctors is severely limited.

Once British doctors have qualified and become partners in General Practice or Consultants they are all nominally equal. Doctors are also strongly independent. British medical organization is, thus, fundamentally syndicalist in nature (Klein 1983). However Strong and Robinson (1990) in discussing this issue argue that

> "every tier must have its leader who monitors, integrates and controls all those who work within that tier and every such leader must be directly responsible to the leader of the tier above. Without such methods,

so it is argued, there is an inexorable tendency for the workforce to wander off and do their own thing."

The freedom that the medical profession as a whole enjoys, enables the profession as individuals to a very large degree to do what it wants. A District General Manager says:

"You may advertise for a general surgeon with an interest in something that the hospital has a need for, but when he is in post he can do what he likes, and that may be completely different."

And this was a view reinforced by two consultants who recognized that consultants could do whatever work interested them, even if it meant ignoring or neglecting other hospital priorities, or even what they were appointed for:

"I was employed as a head and neck surgeon, but my real interest is in cosmetic surgery, so that is what I spend most of my time doing."

"The job was advertised as a otoneurologist basically but now he only does nasal work, and we still have a problem with the otoneurology."

13.2. Some Effects of Clinical Freedom

Strong and Robinson (1990) also argue forcefully that this power of the medical profession has to a large degree moulded every health care system in the Western industrialized world, regardless of its methods of organization. In other words the problem of managing the

medical profession may be seen as universal. However, although medical dominance poses huge problems for each Western nation's attempts at modern health care management, that power can take specific national forms. Strong and Robinson (1990) feel that in the United States the overall system is a mess. At macro level health care is vast, hugely expensive, unfair and even unmanaged at the global level, although some argue that overmanaged might be a more appropriate description. Typical of the comments were this one from a President of an American University Hospital:

> "armies of little clerks and bureaucrats, small armies in hospitals, enormous battalions in insurance companies and governmental agencies; the fact of the matter is there are hundreds of controls. There is enormous inefficiency and consumption of resources by this plethora of administrative, insurance and bureaucratic schemes and systems and services in this country, it is undeniable there are all sorts of statistics that show the relative waste, or at least overexpenditure and administrative costs of bureaucracy."

This comment from a Clinical Director summed up the views of most American consultants:

> "Our health care system is absolutely in a mess, we have the problem with increasing technology, the increasing costs of that, malpractice looming still significantly, and the idea of equal care for everybody, and we are bankrupting the country with what we are doing. And yet we have 37 million uninsured or underinsured, who do not have access to treatment."

But in local affairs the system has shown real achievements. American administrators have different

influences with doctors, and the information on individual activity that a fee for service system provides, has enabled American hospitals to pioneer new methods for medical micro management. A manager at an American hospital illustrated this as follows:

> "The Pap Smear team reduced the turn around time from five weeks to one day. And we did not add any staff. We had already tried adding staff but that did not make it any quicker. It has to do with focusing on the cause, being willing not to leap to a conclusion, just remaining and studying the data and doing experiments and seeing the results in the data."

13.3. Effect of Cash Limiting the Service

But as Chantler (1991) (1992a) and (1992b) consistently points out there is a fundamental difference between a private hospital and a cash limited hospital or service in the NHS. In the private sector the doctor in many ways can be seen as a customer along with the patient because the doctor introduces the patient to the hospital and the patient is responsible either directly or indirectly for paying the cost of treatment. Obviously consultation between the management of the hospital and the doctors is important in order for a proper service to be provided and to ensure reasonable efficiency in the use of resources.

In the cash limited public sector both in the UK and elsewhere in the world difficult choices have to be made

regarding the allocation of resources. Efficiency is paramount because profligacy in one area may deny access or adequate treatment in another. There is an ethical requirement to strive for both clinical efficiency (resource management) and clinical effectiveness (clinical audit).

The British doctor (not in a training grade), is therefore in many ways more independent than his American counterpart and this has obvious consequences on his relationship with managers. The British consultant continues to receive in effect a life time appointment and can not be removed except for major transgressions, although there are indications that this may be changing with the introduction of short term contracts, performance related contracts and a downsizing of the hospitals especially in places like London following the Tomlinson Report (1992).

13.4. Consultants' existing management experience

It is important to recognise what many consultants were very ready to remind me that clinicians are inevitably involved in managing people, departments and resources whether or not they or managers explicitly recognise such as a managerial role. A Clinical Director said:

> "I have a responsibility to make the Department the happiest possible place for people to work in. People

have always looked to me to sort out problems within the department. It is my responsibility to manage, certainly the junior staff, and to some extent the junior Consultants, having a frequent and regular dialogue, so we know what we are all doing, and so that what we do provides a coherent structure of work for the department, that is to say that we do not all go on holiday at the same time, that we do not all do the same sort of operations, and that we do not all pursue the same interests and we leave other interests on one side."

One Clinical Director described his managerial role like this:

"A short term and a long term role. In the short term, the day to day management of the department and patient services, and in particular the freedom and ability to organize clinics and operating lists as I think most efficient for myself and for patients, to make most efficient utilisation of the facilities. The day to day control of things like drugs, support services, X-rays, secretarial services, provision of a service to General Practitioners in the shape of discharge letters and summaries. A teaching role which we are all obliged to perform at least for junior staff, even if we are not involved with medical students.

In the longer term I think all consultants should be thinking about where their specialty is going, how changes which are coming through the system might impact on their future practice, new techniques, development of more personnel, the finances, the requirements of General Practitioners and making best use of resources and having some sort of plan for where they want to be, in say five years in the future."

Reviewing the extent to which these roles are played and how effectively, and whether they should be extended to include more financial aspects of management with more decentralization of responsibility, accountability and authority, it is necessary to consider whether more should be done or could be done to develop the necessary

skills. In the last decade or so there have been increasing attempts to invole doctors in the management of clinical services, particularly in the areas mentioned, in the United States and the United Kingdom (Disken et al 1990) which requires two things to occur;

A. Managers to relinquish central control.

B. Doctors to accept managerial responsibility.

And the first is unfortunately universally resisted by managers. An ex Unit General Manager and now health care academic told me;

> "The classic bad manager is somebody who cannot devolve, who cannot give up control. This is a particular problem in the health service because many managers already have difficulty devolving to other managers, so devolving to professional groups who they feel have no experience in management is even more difficult for them."

13.5. The Cultural Change

To persuade doctors to accept managerial responsibility, in addition to teaching and educating and training doctors to be managers, it is also necessary to organize a culture of understanding health care in the wider context, as well as to encourage doctors to accept more managerial responsibility and to work with managers as a team. A Clinical Director:

"Doctors have an ethical responsibility to ensure that resources are spent wisely to ensure efficiency and effectiveness, particularly so when resources are limited."

But this was not a common view. Many Clinical Directors spoke more like the following quotes from Clinical Directors:

"Finding the funds is not my problem, that is up to the managers. If they want to make cuts, then they must say so, but it must not be me who does it for them, which is the danger of doctors getting involved in management."

"I do not want to give up clinical work to manage."

" Who is going to do my work if I have to spend some of my time managing? They will not employ anyone, the juniors cannot be expected to do it, and they will not pay my colleagues to do it even if they had the time. And what happens when I have finished managing! Where will my job be then?"

So neither of these necessary prerequisites of the change anticipated have so far happened as widely as might have been hoped or expected. Duncan Nichol (1991) said

"that in some areas managers still had to win the respect of consultants. If there is no respect for the leaders they will not be followed. We have to build on that relationship and in some areas we have a long way to go."

The other problem which seems to be developing following the reforms and the move towards more decentralization of management is that the doctors would like to have more managerial authority, and the managers would like to

devolve more responsibility and accountability. Another medically qualified interviewee who had experience as a UGM explained:

> "There is a tendency for central administration to decentralise responsibility but not financial authority or operational authority, whereas the reverse tendency is for clinicians in the decentralised management structure to wish to acquire authority without responsibility and accountability. These issues need to be discussed and worked through for the system to be effective."

13.6. Power Struggles

Some doctors felt that the reform following the White Paper (1989) had lead to an increase of power in favour of managers Lee-Potter (1991);

> "The relationship between doctors and managers has always been delicate, often strained, often heated. The government made it clear in the recent reforms that the Department of Health's doors were open to the ideas of managers, but closed to doctors objections. To the BMA and others the message was clear, in government circles a manager is more important."

Doctors have long feared that management, i.e. general managers and chief executives, were trying to encroach on their long held, professional independence, their freedom to determine their individual work loads and pattern of working and even their clinical freedom. And the view of a number of managers support that belief. A Chief Executive:

"I think that what we badly need is an organization to manage, firstly medical practice and secondly medical people."

Another Chief Executive said:

"I think the White Paper is not about saving money and improving health care but about breaking up the power bases of the consultants, controlling them more tightly and reducing their freedom, which has so far prevented management from managing."

Doctors also fear that managers will remove them further from the decision making machinery thus leaving the mangers free to ignore medical advice. A Clinical Director:

"Once we are employed by the hospital and the Chief Executive is our boss, and we are on short term contracts we will have to do what management says, which may not be what we would have chosen for the patient. We will end up doing operations we are told to do, because they bring in money, and not based on clinical priorities."

Strong and Robinson (1990:xi) support and recognize this when they state that

"the push to control doctors is not a British but a worldwide phenomenon that affects every Western industrialized country.....there is no going back on general management. No politician would willingly give up the power it offers over doctors."

However, that is only one interpretation that has been put on the reforms and the introduction of general management. Others like Chantler, (1991), (1992a), and Griffiths, (1991),(1991b) and (1992), take the view that

general management reforms were not intended to create a new profession of managers but that all staff within the NHS should contribute to the management of the service. This is an issue which has been discussed already in Chapter 2 when considering the third reorganization and the Griffiths Report (1983).

13.7. Personalities and Cultural Differences

Many of the difficulties in the responses of doctors to management stem from their cultural norms contrasting so strongly with the managerial culture. This has already been alluded to in the reference to the work of Handy (1991). Doctors are trained to do all that needs to be done for their patients regardless of the effort or cost. They learn to be self assured in defending their opinions and practices. They are expected to strive for the best available evidence before making a decision. They are used to working to short term immediate goals and they assume managers are working to long term goals, although as we shall see in section 13.6. when I consider the different career structures these are muddled, wrong and misunderstood views.

Doctors rarely receive any training in management or organizational skills. They tend therefore to have a poor grasp of, or indeed little respect for, managerial skills or structures. A General Manager:

"Doctors may also misunderstand their role for medical advice and negotiation and therefore be ineffective in the medical advisory machinery."

Doctors believe managers are there to oil the wheels, ensuring adequate facilities and equipment when they are needed. President of a US hospital:

"the hospital administrator was relegated to a fairly maternal role of clucking around seeing that all these artists [the consultants] were happy and the best administrators were those that were able to keep their craftsmen the happiest."

An ex District General Manager now an academic:

"we were the "oiling the wheels" men, if you like we would bow down to what the surgeon wanted, and help him get there."

13.8. Education

There appears to be a culture amongst consultants that managers are failed doctors or in some other way educational failures. And this is admitted by many managers. Unit General Manager:

"Managers are usually much less well educated; we only had degree courses coming in for managers in the middle sixties thereabouts, and often they were people with middle grade university requirements."

Chief Executive:

"The consultants are much more educated than I am, I do not understand what they are saying sometimes, when they quote Latin or Greek, I just wish they would talk in English."

District General Manager;

"Most medical people coming in recent years have had a very high standard of education. So I think the relationship between the two gets very difficult. We are traditionally rather afraid of the medical profession. And that still exists today, even though there's all this macho management talk".

Another ex DGM and now academic supported these views;

"Only yesterday I met to discuss two consultants with their Clinical Director and a manager and the manager I think wanted me there as an older administrator, one who is used to dealing with doctors as he was worried about how to handle the particular problem he was facing. To say he was frightened was going too far, but there was an element of fear in it."

And the concept of apprehension was reinforced by another comment from a UGM:

"The reality of having to go into the changing room or into the theatre or clinic to meet a surgeon is still daunting for most managers today. The fact that you've got lots of younger ones, and they are changing makes it even more difficult for them."

This attitude was seen even in the United States in the past as an American CEO said about his fellows:

"Lay persons in administration, are not held in high esteem, they were essentially glorified "go-fors" to

the physicians. Now this country has developed a number of academic programmes, higher education programs in health care administration and started pumping out these Master Degree people who are going to be professional administrators".

And it was a view not confined to lack of confidence on the part of the managers; consultants do really believe it is true. Clinical Director:

"The most intelligent, the most highly trained, the most motivated and most workaholic people are the consultants, because society has selected them over many years to be that kind of individual. The best scientific brains in the country have gone into medicine for a long while. Now to simply try and control that group by people who are not as intelligent or so well informed or anything else is bound to run into trouble."

Some consultants are more acerbic:

"Managers in the NHS are just the failures and rejects from business".

Even the British Medical Association speaks in similar terms. According to its Secretary Lee-Potter (1991);

"In a well managed company the best, the brightest, the leaders, are the managers. In the health service the best, the brightest, the leaders, are the doctors."

Some administrators from the States however held some similar views about doctors as an American CEO said about doctors:

"they are being very well trained, but not particularly well educated in the ways of the world!"

Of course such descriptions about sets of cultural attributes can easily slip into stereotypes, and few doctors or managers fit neatly into these ideal types. Many of the medical profession have a constructive and sympathetic view of management and many managers respect the position of the doctors and these views have been discussed in Chapter 12.

13.9. Differing Agendas

Clinical Director:

> "The agenda of the clinicians is not the same as the agenda of the managers or even of the trust or of the purchasers."

Clinical Directors:

> "The clinicians have an agenda and the managers have an agenda. The agenda at the fore front for the managers at the moment is the waiting list initiative to be completed by the end of March. We are spending a lot of management time on that as there is money to go with it. There has been a bit of encouragement to get the clinicians to do extra work for extra money and we are managing to achieve this in most areas."

> "I think there used to be an Us and Them attitude before we became a trust; I think as the budget becomes our budget then it should become an Us and Us relationship. I am quite pleased with the progress we've made, we're not all the way there, but we became a trust last April and I became a Shadow Clinical Director almost two years ago and we've created a corporate being of a Surgical Directorate within a large trust which didn't exist before. So that's a bonus."

Managers and Consultants appear to have different agendas. But a factor complicating this issue is that not all the clinicians nor all the managers appear to have the same agenda either. Colin-Thome (1991) felt managers were the quiet accomplices of some clinicians, striving to improve services often in the teeth of fierce opposition from colleagues. He describes how his local hospital had opposed his proposals for improving patient services, although the manager had accepted and implemented them. However Galbraith (1991) felt that managers were marching through medicine at the behest of the government putting financial considerations before clinical ones:

> "Let loose like bulls in a china shop without the constraints or peer pressure that applied to doctors".

13.10. Differing Power Dependencies

Kotter (1977) introduced me to the term power dependence. He suggests that in complex organizations it becomes more difficult if not impossible for managers to achieve their ends independently or through persuasion and formal authority alone. They need to influence other people on whom they are dependent. He compared the situation of a Plant Manager and a Hospital Manager. Although he did not separate specifically the ideal dependencies, influences and authorities, I thought it might be instructive to compare those of a hospital consultant and

manager or chief executive, which might lead to some interesting ideas.

A doctor's performance is more directly dependent on their individual talents and efforts, whereas a manager may be dependent on superiors, subordinates, peers in other parts of the organization, the subordinates of peers etc. As all the people on whom the manager is dependent have limited time, energy, talent and possibly competing agendas, this may produce frustration and difficulties.

In a paper the following year Kotter (1978) demonstrated the importance of power orientated behaviour to managerial success by showing how much of the working time and energy was engaged in power orientated behaviour. He further demonstrated that variations in power orientated behaviour were closely associated with what he called job related dependence.

Although he recognised that the dependence inherent in a manager's job may be high, medium or low, he did not seek to divide it in any other way or indentify any way other than arbitrary impression on the manager's part of why any particular dependency went into any particular group. I felt that it might be easier to classify the level by considering it in four groups, those that instructions

are taken from, those that account is taken of, those they need help from and lastly those that they rely on.

Managers agreed that they acted on instructions or contracts from G.P.Fund Holders and District Health Authorities as these are now purchasers of the services of the hospital. This was new to the introduction of the internal market within the health service. Previously the General Managers had little contact with or input from the General Practitioners, feeling that this was part of the consultants' work only. In addition they took instructions from the Trust Board of the Hospital, Region, the NHS Management Executive and through them instructions from government. They took account of the local community and therefore future or potential patients. They needed help from staff and relied on their staff.

The Consultants also took instructions from G.P.Fund Holders and General Practitioners themselves rather than the District Purchasing Authorities, as the Consultants were dependent for their work on referral from General Practitioners. To a degree they also took instructions from patients who indicated their agreement to undergo treatment. They also took account of General Practitioners' and colleagues' views in the management of their work, as well as their speciality associations, Region and the profession in more general matters

concerning their work. They needed help from the hospital and colleagues in other specialities in the facilitation of their work and relied on junior doctors for certain routine items of work, although unlike managers they were not dependent on this as they were qualified to do this work themselves if the need should arise.

Consultants and managers listed the powers, influences people and organizations which most affected them in their work as follows:

CONSULTANTS.	MANAGERS.
	Local Politicians.
	Community Health Council.
	Staff.
	Media.
	Government.
	NHS Management Executive.
	Trust Board.
	District Purchasers
	GP Fund Holders
	Public Future Patients
Patients	
General Practitioners	
Colleagues/Consultants	
Speciality	
Profession	
Hospital	

The interesting thing about this, although not entirely unexpected, (the issue was recognized in the previous chapter), is that the common ground is only with the patient or potential patient. Since the introduction of the internal market, the common ground has extended to include general practitioners, particularly if they are Fund Holding practices, because of the need to attract their custom to the hospital. However this is balanced by the relative loss of Regional influences, common influence on both managers who received a considerable managerial input from there, and consultants whose contracts were then held by them.

The other issue about power dependence, and Kotter (1977) discusses this as well, is that trying to control others by directing them on the basis of power associated with one's position does not always work, because there are people who will not accept orders just because the manager is the manager, and do not accept that managers have formal authority. Consultants fall into this category. Chief Executive:

> "There are times when I feel a damn good dictatorship would make my life a lot easier because then you do not have anybody that says "No". You do not get consultants or anybody questioning you. You may be going completely in the wrong way, but at least you are doing it in a comfortable manner."

Clinical Director, about his Chief Executive:

> "He is not my boss, he cannot do what I do, when he can do the operations, and do them as well as I can, then he can tell me what to do."

Another Clinical Director about the Unit Manager:

> "He stands behind me. When he can do the operation as well as I can, then he can stand next to me."

Kotter (1977) feels that the larger the number of job related dependencies the more time and energy the managerial incumbent tends to put into power orientated behaviour to cope with those dependencies. Also the larger the organization the more the manager must depend on other specialities and support services. Both of these have implications for the doctor manager relationship. In arguing the case of the dependency problems of the hospital manager Kotter (1978) feels that it is important and useful for the manager to exhibit in such situations a high profile availability and to be seen about the hospital. Clinical Director:

> "I want a chap who at 11 am, in say a coffee break, pops his nose in for a cup of coffee and says, how are things going, what are the problems? By the way I think you ought to know this, I think you ought to know that, and incidentally that operation you did the other day cost x number of pounds, I hope it was a success. In other words a chap who is popping in, chatting to people, knows everybody, a friend of the family. Now, he only needs to come in for half an hour a week. He can see everybody in the departments in half an hour once a week, but I want to see the chap, and I want him to know what is going on day by day."

Medically and dentally qualified Unit General Manager:

> "Managers in the NHS spend too much time in their offices and not enough time in the hospital, getting a feel of what is going on, getting to know the people who do the work."

Clinical Director:

> "I have never ever seen our Chief Executive in our department, or outpatients, let alone in theatre. Some of the staff would not know him."

Even one Chief Executive agreed:

> "Managers do not spend enough time going round the hospital, through wards, into theatre."

West (1988:103) thought this different style of management in the NHS was because so much of the senior management task is negotiation with key groups rather than day to day control of individual departments, so that managers spend most of their time in meetings and much less on walking about.

13.11. Differing Career Structures

Managers stressed the virtues of interpersonal skills and of enlisting the co operation of others. They expect to subsume individual interests to those of the organization. They were trained to be aware of the wider

implication of any activity within the organization and were expected to make optimal use of limited resources.

Managers are normally trained to work to long term goals though this may not always be very evident in the health service where managers are usually only in post in any one hospital for comparatively short periods compared to a consultant. District General Manager:

> "I felt very acutely as a young administrator, moving every two years, that whenever I talked to surgeons or physicians, they would say, you are only here for a short while, we have heard it all before. And so, in any department, you were starting on the wrong foot because they were very unhappy with that, but with the advantage that at least if the person was no good, at least they only had to wait two years to have somebody else."

ex District General Manager and now an academic:

> "The lack of continuity in management is a major flaw. Or at least was; I think it is just as bad as it was, but I am a bit out of touch. The continuity provided by the consultants is a major plus, with the reservation that people get stale and get very insular and are not prepared to look outside. So you could argue that perhaps the two together could provide a good balance. But it is unfortunate that they are different professions, rather than different individuals with the balance."

Manager:

> "If I was going to change just one thing I would rather have some more continuity for managers than lots more instability amongst the seniors, because you don't have one surgeon, you usually have two, three or more and you would be very unfortunate if they were all the same age, so there is some turn around. Also there are a large number of physicians and surgeons in most DGH's

so it is not as if you have eighty people who are all the same age."

Clinical Director:

"They come and go every few years, they never have to live with the mess they make. I've seen it all before, they all make the same mistakes, then move on."

13.12.0. Managers' and Doctors' attitudes to each other

So far I have discussed the findings of the doctors and managers in how they see their own roles, their cultural, educational, agenda, personality, and career differences etc. In this chapter on the findings I thought it helpful to gather together not only the views which they wished to unburden about each other, but also to suggest ways in which they suggested one might help and understand the other.

13.12.1. Managers' views of Doctors' Management Skills

Some managers have graciously acknowledged, with perhaps some surprise, the aptitude of some consultants for management and admitted they had under rated their abilities in the past. DGM:

"There's no doubt that many doctors would make excellent managers and I do believe it's about the balance of that and certainly in debates in terms of sharing the organisation the contribution that comes from doctors is very, very important. Very influential and quite essential when you want to deliver change, so what I am saying is that there is a

very important contribution to be made as with all other managers.

I think doctors are no better equipped than other professionals, because at the end of the day it's about how they can, have they got the basic skills, basic personality, to withstand the pressures on them. I think in some ways the pressures on doctors from their colleagues are greater than other managerial groups. But I'm thinking it could work, though it depends on the situation."

And another DGM:

"If I can draw from experiences that I have had from working with doctors in management, I think the following things come to the fore. Some are very good, they really ought to pack up and become managers because they actually display a talent for it, and they can impact on the organization in a much greater way, than perhaps others are able to."

Some also recognized the problems it created for doctors by becoming involved in management. A DGM;

"The one person I know who wanted to really get involved became totally ostracised by his colleagues. There are tensions about doctors in management and whether they are acceptable to other doctors, or whether they are seen as having passed a divide."

Another referring more specifically to the problems of elected representatives rather than Clinical Directors who are appointed:

"They usually have intense difficulties dealing with their colleagues in a managerial sense, both because their colleagues are actually more awkward with them I would say than with managers from other disciplines on occasion, and secondly, which I've always found quite interesting, because of the theory that if you've got doctors in charge then the doctors will do it - that's silly really. I think for many of them particularly in systems which are elected, or for time barred

things, common patterns of behaviour appear, it's like Chairmen of the Medical Staff Committee, you know if they're there for three years you give them six months you've got to make sure that any hard decisions are taken within the period of the first eighteen months, because after that eighteen months they're busy thinking what people will do to them when they go back. But I don't believe elected systems actually work, and they place people in too many difficult situations."

And another DGM referred to the question of doctors' tribalism, seeing themselves primarily as doctors and only then as managers:

"There are also all sorts of personal problems that come into play, that influence the way they behave when they are in managerial posts. Many doctors believe, that although they are individuals, they are brought up to stick to the great body of doctoring as priority number one. That raises conflicts which in my view are not always conducive to success in management."

13.13. Ways in which Change can be Assisted

It was suggested that there are a number of ways in which managers could help doctors fulfil their role in management.

Firstly managers must show more understanding of the doctors' point of view, and make sure that efforts which any doctor makes to improve a hospital service has some direct and immediate effect on his own department. Chief Executive:

"For instance when consultants make efforts to improve the management of their service either in terms of efficiency savings or income generation it is vital that their department receives much of the benefit and

they do not see it spirited away to a central fund. Without some incentive, disillusionment can quickly arise."

A common and often successful argument which plays on both the doctors' fears and needs has been to stress that they must either help to manage or be managed, that unless they become involved in managing their services it will be done for them, perhaps by people who are less aware of the issues as seen by the doctors on the ground.

Chief Executive:

"This ploy has been rather over used and is easily and increasingly countered by the argument that only doctors can make many of the decisions and therefore this argument has been seen as an empty threat."

A few managers have acknowledged that their lack of medical knowledge has been a handicap, not only in their dealings with the medical profession but also in their work. The courses to help managers learn about medicine have in the words of one DGM:

"Been a great help in my work and in breaking down the barriers of misunderstanding between managers and doctors, and yet there is a enormous way to go yet."

And doctors have shown ignorance too. Sometimes managers assume, often incorrectly that doctors are easily able to interpret the information for themselves particularly financial information. Gross ignorance here can damage doctors' credibility in the eyes of management.

Management decisions which sometimes look arbitrary or ill advised to clinicians, often are so because they rest on incomplete information and/or appreciation by management of clinical actions and developments of the clinicians. Doctors need therefore to ensure that management is informed and understands any changes in their current activity likely to have resource implications, and longer term developments or technical improvements that they plan to introduce.

13.14. Doctors' Views of Managers

Some managers have demonstrated basic misconceptions about medical matters and have thereby allowed the doctors to dismiss them as naive about health matters. Clinical Director:

> "Our Chief Executive could not understand why notes from other doctors or hospitals relating to a patient's previous treatment might be valuable. "Surely our own hospital notes are adequate?"

Other managers have lost credibility by appearing unduly patronising, or by promising more than they could reasonably deliver.

Management information is a potentially useful tool in building up the role of doctors in management. But again management credibility is damaged if the information is

inaccurate. And if the information is accurate, medically qualified Ex UGM said:

> "Managers lose credibility by misunderstanding or even by failing to show that they understand its clinical or epidemiological implications."

Doctors need to keep in touch with colleagues using directorate meetings as a forum to establish effective clear channels of communication between management and clinicians, so that management is kept informed of any change likely to have resource implications, and similarly so that they themselves are able to keep informed of the intentions of the management.

General managers and chief executives usually seem relatively unaware that the doctors are suspicious and fearful, and of the extent to wich consusltants feel this about managers. There appear to be four main reasons for this although this is by no means inclusive of all reasons given.

13.15. Erosion of Values

Doctors have always felt that health care is distinctive and special, a feature that makes it unresponsive and not appropriate for a managerial or commercial approach. Ethical values, it is felt, should not be tainted by a business mentality. Consultants often see discussions of

resources as somehow improper, believing that such discussion conflicts with their responsibility to the individual patient.

There is a fear that more management power may lead to a financially led assessment of health care, thereby forcing doctors to make decisions on economic rather than clinical grounds. Many words and phrases seem to have different connotations with the two groups. Phrases such as "quality assurance", "performance review", "objective setting", "monitoring", and "efficiency" may be interpreted by consultants as tools for either checking up on doctors or for cutting services.

Doctors see the use of terms like "consumer" in place of "patient", or "marketing", "public relations", or "annual report", as evidence that health service values are being replaced by commercial ones. There are often mutual misunderstandings of the significance of particular words and hence of each other's values.

13.16. Erosion of Clinical Freedom

In Chapters 5 and 6 I discussed Clinical Freedom and some of the issues surrounding that. Some doctors see managers as bureaucratic henchmen, in post to ensure that instructions from the centre are implemented. Individual performance review and performance related pay for

managers has exacerbated these fears that a manager worried about an adverse personal review might act more as an agent of the centre, and have a drastic effect on doctors' clinical freedom.

13.17. Conclusions

The successful relationship between managers and doctors is crucial to the success of a hospital, and resolving the differences between the two groups is essential to a constructive and collaborative relationship. "Doctors and managers must build up a relationship of mutual trust if the NHS reforms are to work." Nichol (1991:10):

> "We need to sustain the unique doctor-patient relationship and then build a new and mutually supportive doctor-manager relationship."

Chawner (1991) hoped that managers would no longer talk about doctors being involved in management but of their being part of management. This is something which is becoming very much part of the culture of change in many of the hospitals I studied. No longer is the "them and us" attitude the norm; more and more I have found managers willing to share responsibility with doctors, but many doctors are coming to realize that this is the way to make progress with this issue. There remain two main problems: firstly the big group of doctors who are so far unwilling to accept the challenge for some or all

of the reasons outlined; and secondly the problem of giving doctors responsibility, making them accountable but not giving them equal measures of authority, particularly financial authority. This issue has been discussed in Chapter 3 section 3.7.4., touched on also in section 3.2. and will be returned to in Chapter 17. However before that I would like to discuss in the next chapter the management skills required of doctors in running clinical services and ways of encouraging them to become more involved in management.

CHAPTER 14

DOCTORS' MANAGEMENT SKILLS AND SUPPORT REQUIRED

14.0. Introduction

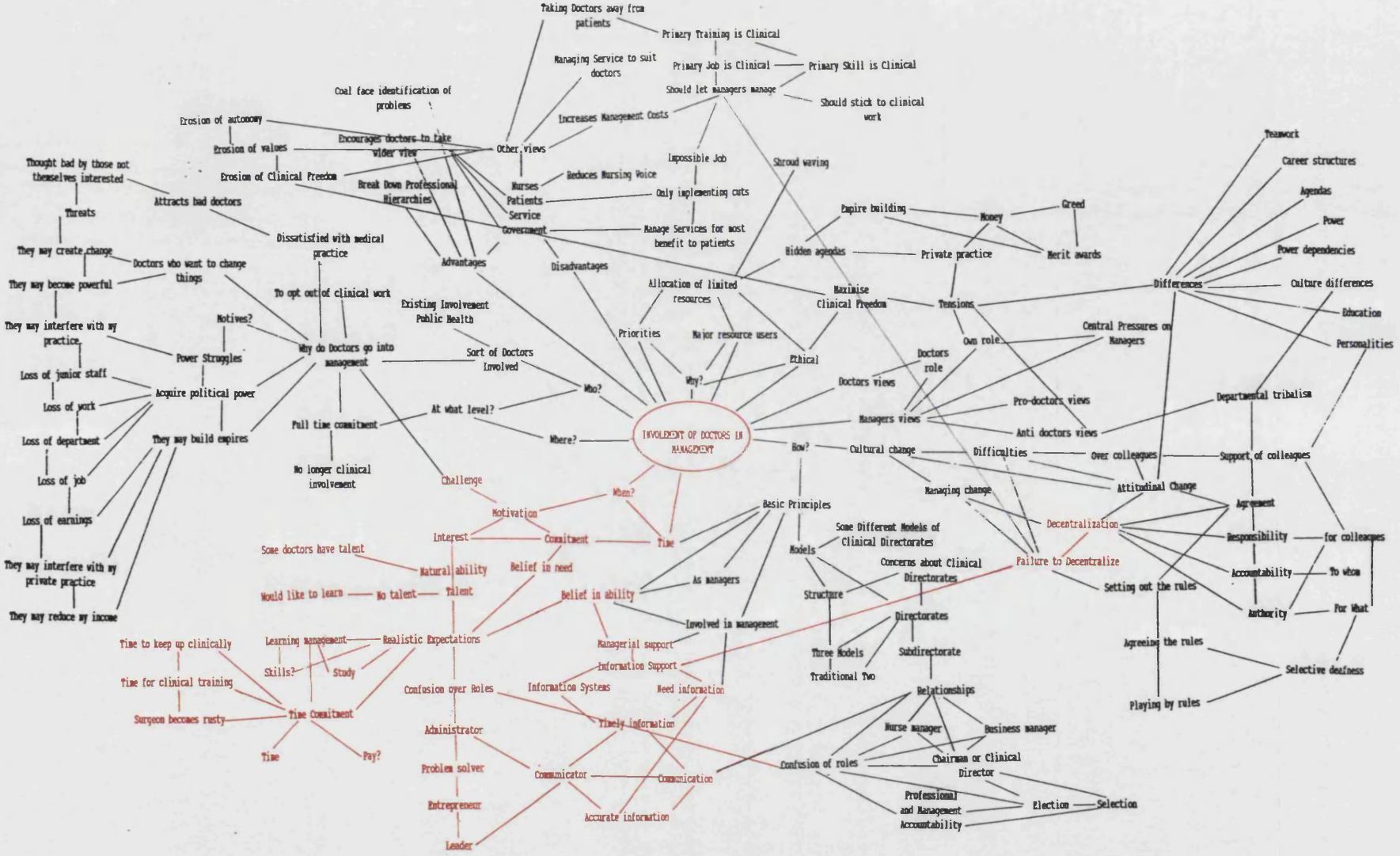
In this chapter I will discuss various management skills which Clinical Directors and Managers have felt are necessary for them to fulfil that role successfully. And later in the chapter I will consider some ways in which doctors can be encouraged and supported to undertake management roles. Again these are highlighted on the cognitive map on page 361 overleaf.

14.1. Commitment

There are different levels of commitment by consultants to management just as there are different levels of management skills possessed by consultants. The first can be identified as follows, based on a typology by White (1992b):

1. Leaders. Those who understand and are committed to the contribution of a management role to patient care.

"I think that we have to be involved, we have an ethical duty to ensure that limited resources are used to the best possible advantage."



COGNITIVE MAP CHAPTER 14
THE MANAGEMENT SKILLS AND SUPPORT REQUIRED

2. Helpers. Those who see it in their interest to become involved in what they see as management.

"If doctors don't become involved then someone else will take control from us."

3. Followers. Those who can detect a shift in the balance of power and realise that it is in their interest to become involved in management.

"There is a tide running at the moment in favour of doctors controlling resources more. If that is how it is going to be, then I think we should make sure we remain on the winning side as it were."

4. Opposers. Oblivious to management and typified by their comment;

"I am only here to treat patients."

People can of course vary in their level of commitment according to mood and circumstance, but on the whole it is an evolutionary process to proceed up the scale. Some of those at stage 2 can be dangerous, being there for the wrong reasons and seeing no reason or value to aim for stage 1. Most efforts and study seem at present to focus on the first group, those who in the words of a medically qualified UGM

"Demonstrate motivation, commitment and enthusiasm for the management process."

It is the other groups that I shall return to in my final chapter outlining the directions for further work.

14.2. The Management Skills

Mintzberg's (1973) classic research on the managers' ten roles suggests that they are under constant pressure to acquire and disseminate information, to develop strategies without time for analysis, to influence the behaviour of others without being dictatorial, to react sensibly to external initiatives without creating an impression of weakness, all of which require a manager to develop a network of relationships which depend critically on the art of communication. He classified these management roles as:

Interpersonal Roles.

Leader,figurehead and liaison.

Informational Roles.

Monitor, disseminator and spokesman.

Decisional Roles.

Planner, disturbance handler, resource allocator and entrepreneur.

Handy (1985:363) put the three roles more colloquially as:

Leading.

Administrating.

Fixing.

It was therefore instructive to consider the roles of the Clinical Director under these headings and to identify existing roles and areas where there might be difficulty in involving doctors in management.

14.2.1. The Interpersonal Roles.

These are the leadership roles. Doctors have difficulty with leadership roles; at least they have problems with what might be called followership roles. Consultants especially see themselves as autonomous; they recognize no boss. Clinical Director:

> "We talk a lot about leadership in medicine, we seldom talk about followership, talk about being the good citizen, without being the leader and I think that's something else that probably needs to be cultivated among medical staff."

The Clinical Director is frequently the leader of the directorate and takes full responsibility for devolved operational management. Clinical Director;

> "You need to be creative, ambitious and a leader."

Motivation and enthusiasm are required to set the style and pace of the directorate. The Clinical Director is the one person accountable, leading the decision making process but also ensuring that others are empowered to make decisions, an enabler and facilitator. UGM:

> "One of the problems we encountered was that having devolved authority to Clinical Directors, they seemed unwilling or unable to devolve it onwards."

One Clinical Director referred to a recognition of this:

> "Delegation of leadership means people are more in touch with leadership."

There is a clear responsibility to determine directorate organizational behaviour and standards, to be a powerful voice in what the directorate does and how it does it, to be responsible for issues of audit, review and evaluation, staff development and appraisal, and to determine whether the directorate has a high or low profile. The management style of the directorate is set by the manner, behaviour and actions of the Clinical Director. The Clinical Director may act as a role model for others, and it is a responsibility to provide an effective and successful role model which other staff wish to emulate.

Leadership also includes the ability to inspire and influence others to work towards the attainment of objectives and goals. This is necessary because of the task of getting work done by and through others. It is therefore necessary to choose a method of leadership appropriate to the situation. People need to be motivated. Clinical Director;

> "The best motivator is challenge which then allows for a feeling of achievement, although it has to be followed by recognition."

Clinical Directors need particularly strong leadership qualities to establish a directorate from scratch. Later, in just running it with the help of business and nurse managers, they need to create a team spirit not only amongst the immediate team (the business and nurse manager), but also amongst all the members of the directorate. Typical were the following quotes of Clinical Directors;

> "Their responsibilities [referring to the Clinical Directors] aren't just fiscal, they're also to do with managing people and playing a part in a multi-disciplinary team."

> "In a Clinical Directorate, there is a doctor, an administrator and a nurse. That is the management team for the Clinical Directorate."

> "It is important to try to engender a team approach, delegating responsibilities, for example giving ward sister control over everything that happens on the ward."

"The emphasis is on a team approach, the basic team comprising the doctor, the business manager and the nurse manager working together."

And a UGM referring to the difficulty one Clinical Director had with the idea of teamwork described a situation:

"Where one of the Clinical Directors, who never liked the system and had not really played as part of the team."

A well defined directorate leadership acknowledges, respects, values and uses professional differences, similarities and contributions. Clinical Director;

"One has to be able to recognize good ideas from all members of the directorate team."

A clinical director must invest all the members with a sense of identity in the directorate, helping other consultants to adapt and contribute fully to the new structure and process; analyse problems, make decisions, accept responsibility for those decisions and be accountable for those decisions, being part of the corporate hospital management; Establishing clear complementary and effective roles and responsibilities with the other managers of the directorate, and review and update them as the skills of each develop.

14.4.2. Informational Roles

The flow of information is a multi directional process to reach superiors, subordinates and peers.

The Clinical Director was seen as a spokesperson, coordinating a medical input into management information providing in one direction a clinical perspective to management but also allowing colleagues to debate and influence management decisions. Clinical Director;

> "I am there to enable clinical colleagues to know about things, so that they can be discussed and a view to be represented to management."

In the other direction it ensures colleagues are informed of management decisions, ensuring clear, relevant, informative and comprehensive communication. Clinical Director again:

> "I am able to tell them what the Management Board decided, and also why they came to that decision."

The importance of clear accurate lines of communication was stressed many times by Clinical Directors, for example:

> "The information going out of the directorate must be realistic and accurate and the incoming messages must be clear."

What was not clearly stated so often was the need to communicate across the organization, between directorates. One Clinical Director noted;

> "But also there needs to be a link [referring to communications] transversely with other directorates, and that tends to be forgotten."

Good communication within the directorate and between other directorates is a process of people relating to one another, listening, empathizing, checking, understanding, providing feedback. Clinical Director;

> "It is vital to have really good communication skills to prevent and diffuse potential areas of difficulty with staff and colleagues."

Information and communication skills and networks are important and the Clinical Director uses his influence to ensure that these are good. Clinical Director;

> "We have to learn that consulting with others and taking their advice is about building strengths and not about admitting your weaknesses."

Many clinical directors feel particular vulnerability in expressing a need for guidance, support and learning for themselves. The Clinical Director needs to be able to relate in groups, or one to one situations, to be able o lead discussions and meetings competently, to prepare and present arguments based on facts, and to resolve claims on competing resources. Clinical Director:

"Reluctance to admit the need for guidance can hinder personal, professional and directorate growth and is not a good example to colleagues."

Directorate culture must be to support all staff development within the group. Wraith and Casey (1992) feel that external resources provided by other sites, academic institutions and organizations should be fully utilised for this purpose.

It is as important that the hospital listens as readily as it talks. What is important here is whether the Clinical Director has an adequate voice in the corporate decision making process. Several Clinical Directors stressed that they had no really effective voice as they were not on or represented on any management board or committee. One Clinical Director typified this:

"I am working very much in isolation, I go to the MEC and I hear what we are told, they might just as well write me a letter, the meeting is just to tell us what is happening and what we are expected to do. There is no listening to what we might have to say, the decisions have already been taken at a higher level."

The dilemma of how many Clinical Directors make for an effective corporate management and decision making body is an issue to which no one has yet provided a satisfactory answer. The BMA/CCSC (1990) emphasise

" the requirement that the management body is not too large to be unworkable".

It is an issue raised on a number of occasions. To some extent it depends on the size of the hospital, but it also relates to the time available, and the management skills and ability of the Medical Director. A medically qualified ex UGM summed it up:

> "The more Clinical Directors on the Board the better for the organization, but it vastly increases the work of the chairman, who is usually the Medical Director, who must do most of the work outside the committee before the meeting, ensuring that everything runs smoothly."

Part of the current role of Clinical Directors is to ensure that effective audit mechanisms are in place, that reporting of audit is occurring and that improvements and changes are monitored to improve effectiveness. (White 1992c). This responsibility for the quality management or effectiveness of the organisation is brought closer to the patient by an impact on the quality of service delivered. Quality needs to be understood and embraced as an integral part of everything everyone does. People need to see the impact of their own particular contribution to the success of the organization as a whole. Clinical Director:

> "The managing of a balance between quality, quantity and cost, particularly quality in contracts will probably be a more important part of the Clinical Director's future role."

14.2.3. Decision Making Roles

Uncertainty has now become the expected way of life in hospital rather than an occasional threat. There is a greater emphasis on opportunities rather than on problems, on creativity rather than routine and control. Clinical Director:

> "Innovatory practice is valued, but it has to be and rewarded. Implicit in that is the expectation and acceptance of the possibility of making mistakes, of learning from them and modifying practices accordingly. This risk taking and its consequences need to be openly supported however."

For Clinical Directors dealing with conflicts is often a problem. Chief Executive:

> "Doctors have problems with negotiation and conflict. Doctors have difficulty in believing in teams. They see committees as looking after territory rather than the whole organizations."

And two Clinical Directors said:

> "The most difficult thing is dealing with personnel problems. I had never been involved in a disciplinary issue before. Fortunately I had full support from the personnel department."

> "This relates very much to working with people, being aware of others and seeing things from another person's perspective, to read or interpret other people's thoughts and feeling even when they are not obvious, developing others and working as a team."

They also have difficulty thinking strategically, to make a stand on critical issues. Problems need to be faced openly and honestly. An increasingly important role for the Clinical Director is influencing the activity of the directorate in the identification of opportunities and encouraging and developing awareness of business planning in colleagues, leading the discussion to analyse issues and make decisions, and agreeing realistic achievable activity levels through contracts. Clinical Director;

> "I have to ensure that business plans are reasonable, achievable, acceptable to colleagues and subsequently monitor them, analysing progress against the plan and expenditure against budget at monthly intervals and taking appropriate action if the results are not matching targets."

Meetings and discussions with medical and other staff may be necessary before agreeing work patterns and targets within the directorate and to monitor progress through the year and to ensure they are consistent with the overall objectives of the hospital.

Financial management was an issue discussed many times. As many Clinical Directors, CEs and UGMs pointed out:

> "You need to get your hands on control of the money, if you are to play any meaningful role in management."

Clinical Directors need to know who really makes the decisions and how. A UGM suggested that a good test was

"to take as an example take a recent piece of equipment and find out who really made the decision to buy it."

To be part of the management structure the Clinical Directors have to be part of that process. But in addition they need to be informed of the total budget position of the hospital; a budget in isolation may be meaningless. A Clinical Director summed up the financial management role as having three parts:

"Firstly accepting financial responsibility for provision of defined services although only after personal involvement in the negotiation. Secondly encouraging financial awareness among colleagues and participation a in financial review of the directorate. And thirdly to advise on clinical priorities so ensuring that the directorate stays within budget."

Many Clinical Directors stressed the need to have mechanisms in place to monitor the financial performance, so that corrective action could be taken as appropriate, operating within the statute, rules and conventions of trusts or self governing unit. One UGM warned:

"The rules need to be set out beforehand. Management retains its power by not setting out the rules beforehand."

14.3. Attitudinal Change

There are certain prerequisites to involving doctors in management. The most important lesson from the introduction of clinical management is the need to change attitudes of all the people concerned. The views of

several Clinical Directors when discussing the thing they would most like to see change are summarised by this view from a Medical Director:

> "I would most like to see a change in the attitude of my colleagues."

and a consultant who had spend some years as a UGM summed up the views of a number of Clinical Directors:

> "The importance of getting the structure right has to take second place. If this change of attitude is not properly discussed and debated before introducing a system it is unlikely to be successful and these discussions and decisions which should take precedence over the introduction of information systems."

It was shown to me by many doctors and managers that there had been an increasing if reluctant acceptance by many clinicians of the reality of cash limits, and within that the ethical responsibility of all concerned to ensure that resources were spent wisely to ensure efficiency and effectiveness. One Clinical Director put it like this:

> "Where money is limited, extravagance or even lack of concern for the financial repercussions in the care of one patient, may lead to the reduction or denial of care for another."

Constant attention is now accepted by many to the idea of improving efficiency in financial and economic terms and to ensuring the effectiveness and validity of treatment to produce the best outcome. This, of course, links

into the range of initiatives described in Chapter 3 (Doctors and Hospitals) section 3.5.1-3., in the management of resources, clinical efficiency and also the more recent development of medical and clinical audit, i.e. clinical effectiveness.

14.4. Time Commitment

One of the issues raised with great frequency was the question of time. Everyone agreed that if clinicians are to be involved in management they need be allowed to fulfil that responsibility on a part time basis. The problem is that if they are required to devote too much of their time to their management function, then they will cease to be clinicians and the views of several Clinical Directors and some Managers could be summed up by the following remark from a Clinical Director:

> "their unique perspective as clinicians will no longer be contributing to the management task."

The general feeling was that given that an important part of the task of the Clinical Director is leadership, this role would be inhibited if he were no longer a clinician. One Clinical Director said:

> "Once a doctor is so involved in management that he becomes a manager full time he ceases to be a doctor; in the eyes of his colleagues he is a manager. It is as simple as that."

14.5. Managerial Support

If doctors are to fulfil these managerial responsibilities on a part time basis, then the Clinical Director must be prepared to share responsibility with other members of the management team, recognizing that the Clinical Director role is managing and not administration. They need to be supported by able business managers and nurse managers. The emphasis is on a team approach and the basic team comprises the doctor, the business manager and the nurse manager working together. The intra group relationships can take one of three forms, White (1992), and the leader does not necessarily need to be a doctor although the tendency has been for this, nor does a leader need to be agreed explicitly Clinical Director Ex UGM:

> "The leadership of this group does not need to be specified, though the tendency has been at least initially for this role to be filled by the doctor."

And Ross (1992) agrees:

> "The most suitable person should be the Clinical Director, not necessarily a doctor".

14.6.0. Information Support

Some of the hospitals studied are not decentralizing but retaining power at the centre by retaining information. This is a common complaint of Clinical Directors:

> "I would like to have some more information."
>
> "This role [referring to being Clinical Director] would be a whole lot easier if I had access to basic, reliable information."
>
> "They expect you to do things with virtually no information."
>
> "The trouble is the information I get is always about two months old by the time we get it. By then it is pretty useless for most purposes, it's just history."
>
> "There seems to be a lot of information available in the district offices, although I'm not sure how accurate it is, but trying to get hold of it is mighty difficult. They seem reluctant to share it."

It is important that information available within the directorate is accurate and timely if a Clinical Director is to be usefully involved in management. Clinical Director in centralized unit struggling to devolve:

> "I would like direct access to information, activity data etc."

Another view was taken by the Chief Executive of a well decentralized hospital:

"I expect the Clinical Directors to be responsible for collecting their own information and telling us what is happening, and why, and what they are doing about getting it right if things are going off track. Not the old way of information coming down from on high, and the MEC being told that it was all wrong. They can't say the information is wrong now, because they produce it themselves."

It was generally felt that many of the roles concerned with information should be the prime responsibility of the Business Manager, particularly the gathering of relevant information. It might be necessary for the Business Manager to review and refine available information. But the Clinical Director uses that information for problem analysis and solving and to disseminating information to colleagues following management decisions. One Clinical Director put it like this:

"She [referring to the Business Manager] collects the information, analyses it and presents it at our weekly meetings; everyone knows what is going on, how we are doing on targets for contracts, and I can make decisions on any changes that need to be made."

14.6.1. Information systems

It is argued by some consultants that one cannot manage without sophisticated information systems. One Clinical Director said;

"It is all very well wanting me to manage the department but I just don't have the computer equipment to do it."

While this idea is widespread, it is the case that the better the information the better the management function can be. A Clinical Director:

> "Once we started to get the right information, and we could rely on its accuracy, things became a lot easier."

A few Clinical Directors believed that it was perfectly possible to run a clinical directorate without sophisticated information technology. One said:

> "All you need is a notebook and a pencil to keep a record of what is going on."

Several Clinical Directors in successfully decentralized units stressed the point that information systems should be designed in the first place to improve the running of the clinical directorate and in the provision of the clinical service and only then should the necessary management information required both in the periphery and centrally be added on.

They also stressed that it was vital to introduce new accounting systems which were not functionally based in the traditional manner but which detailed all costs incurred within the decentralised structures. Clinical Director:

> "I need to see a budget sheet showing the details of what is happening within the directorate, showing me exactly what the money is being spent on."

14.7. Having Realistic Expectations

What is it that management hopes, demands and expects from doctors involved in management? This was neatly summarised as follows by a C.E. referring to his expectations of the Clinical Directors in his hospital:

> " I demand integrity. I hope for the best. And I expect a considerable variation in performance from different Clinical Directors."

What they get seems to be varying levels of competence at the role. But competence can be classified too into three main groups. One Chief Executive neatly put it like this:

> " First there is natural ability, although that ability maybe doubted by the individual Clinical Director. Then there is trainability, that is to say those who can do a reasonable job when trained. And thirdly there is unbelievability, by which I mean those who think they can do it but can never learn how."

What came across strongly from the participants was a belief in the need for doctors to be involved, that belief being held by both managers and doctors. But it was also thought necessary for the doctors to have a belief in their own value and capacity to undertake the roles required, albeit with training, as touched upon by the Chief Executive mentioned in the quotation above. And finally there was a need to take account of time,

time for undertaking the roles, time for training in the necessary skills, but above all a recognition that it was a part time role with continuing clinical commitment.

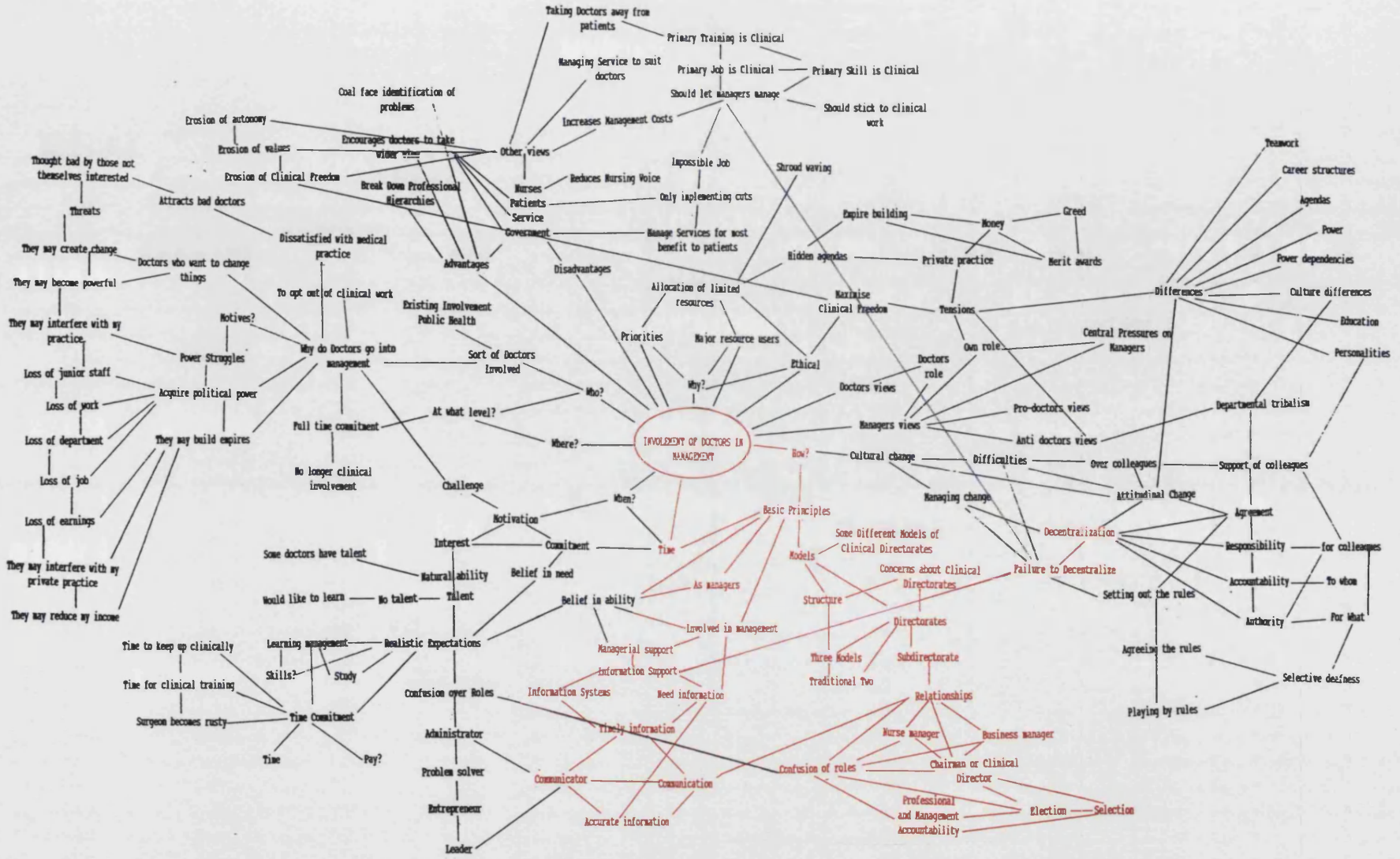
CHAPTER 15

MODELS OF HOSPITAL CLINICAL MANAGEMENT

15.0. Introduction

This chapter, again highlighted in the cognitive map on the next page (p.384) discusses the ideas and models currently being tried to involve doctors in management of hospitals. Some of the problems are discussed, for example whether Clinical Directors are elected or selected, the problems of setting up clinical directorates, failure to centralize and confusion over roles. Then various styles of Clinical Director are introduced highlighting differences. Some well known examples of clinical directorate structure are discussed before setting out some basic principles and areas of concern. Finally having considered on one level the problems of how to involve doctors, later at a more radical level, the question is raised whether doctors should be involved.

Some hospitals have attempted to encourage their medical professionals to participate more in managing the hospital by becoming responsible for their colleagues as part of the management structure. Other hospitals have felt that the extent to which they are truly involved depends on the degree to which those professionals, as



COGNITIVE MAP CHAPTER 15
HOW MODELS OF CLINICAL MANAGEMENT ARE EMERGING

managers, have been given some financial independence, an issue discussed in the previous chapter Section 14,2.3. A general General Manager's comment was typical:

> "You need to give them [the doctors] hands on control of the money"

This view is supported by West (1988:98);

> "a great deal will depend on the extent to which managers (professionals involved in management) at each level have some financial independence".

Equally important is the extent to which such clinical directors can take a corporate view and see themselves as part of the hospital management, West again; (1988:98)

> "Equally important is the extent to which such managers (professionals involved in management) see themselves as part of the hospital management or first and foremost as part of their own department".

one UGM described this as

> "Breaking out of their tribal groups"

as opposed to being first and foremost part of, and representing, their own department. This departmental or representative attitude is typified by the following comment from a Clinical Director in a centralized hospital:

> "I represent the department, put my department's point of view and generally fight to get what my department feels it needs. And also to make sure we do not lose out to other departments."

There have in the past been specialised managers of certain departments of the hospital, for example an X-ray department represented by its superintendent or consultant radiologist, the pathology laboratory probably by a consultant pathologist, the audiology department, an audiological scientist, consultant otolaryngologist or audiological physician, and beyond that the ward sister, the firm consultant, etc., but as a medically qualified ex UGM, now academic pointed out,

> "They were usually competitors for resources not allies within the general organization, and the resources they were given were set by those in local control of the whole service".

15.1. Clinical Involvement in Management of a Hospital

In any discussion it is important to distinguish between the clinical management structure within a unit or department and the management structure within the hospital, district or trust. The two are different structurally with important differences of emphasis, and the structure within one does not necessarily reflect the structure within the other.

It is also important not to confuse the Trust Boards of a hospital which are generally for strategic management, and where medical input is from a Medical Director, and the Management Boards which are for the operational management of the hospital or trust although they may from time to time need to take a strategic view, and where medical input comes from the Clinical Directors. The roles of the Medical Director and Clinical Directors are different, although one hospital in my study has attempted to combine these roles.

The clinical directorate is for the operational management of the faculty or department or unit within the hospital, and again although it is primarily an operational unit, the clinical director may need to take a strategic view at times. Clinical Director:

> "Management can be broadly divided into two parts, namely guidance or strategy and delivery or operational management. The task of a clinical directorate is mainly operational management but the Clinical Director representing the clinical group should have a voice in strategy."

Discussion in this chapter is therefore limited to doctors' involvement in the management structure at directorate level, i.e., as Clinical Directors.

15.2. Clinical Directorates

A number of hospitals have increasingly been experimenting with variations of the so called clinical directorate management structure. All the hospitals which I studied claimed to have adopted a clinical directorate structure to manage clinical activity. This is the latest in a series of efforts to secure the active participation of clinical staff in the management of a hospital. The chief executive of the NHS made this plea at a seminar on clinical directorates (Nichol, 1990):

> "Doctors and managers must build up a relationship of mutual dependence if the NHS reforms are to work"

He went on to say that there was a need to sustain the unique doctor patient relationship and then build a new and mutually supportive doctor manager relationship, an issue to be addressed in later chapters.

There is however, not one clinical directorate structure; there are many variations and no one example seems to be clearly better than another, but whatever arrangement is chosen or found, for it to work well, it has to be that which is best suited to that hospital, given all the local factors namely of size, history, personalities and whether the hospital is on one site or several. There are certain principles associated with success or failure. In studying this aspect, one of the problems is

that what hospitals think and profess to have chosen as a clinical directorate structure, does not always bear any resemblance to what an outside researcher can observe.

Examples from various acute hospitals have been studied from a small hospital having six Clinical Directors with no decentralization of management, to a large hospital with twenty four Clinical Directors and again no decentralization although claiming to be fully devolved. On the other hand I have studied small and medium sized hospitals with good decentralization and four to six or seven Clinical Directors as well as large hospitals with twenty or more Clinical Directors.

In the smaller hospitals there seem to be typically four, five or six directorates with some of the larger hospitals having up to double that number. There are hospitals with over twenty and at least one hospital is planning to introduce fifty or sixty directorates. In large hospitals where there are between one and two hundred consultants it is usual, although by no means universal, to split directorates into sub-directorates or associate directorates. In this situation it is often the clinical directors who have difficulty in devolving their managerial control. Consultant and Ex UGM:

> "It's curious, because we've actually come across another problem since. We feel that we have to de-centralize further than the fifteen Clinical Directorates, down to Clinical Teams within the new

health service. I think it's absolutely essential, but it is the devil's own job to persuade Clinical Directors to decentralize. And we are actually having to change our whole management system now because the resistance they have put up to opening certain areas, to allowing that further decentralization to take place."

There appear to be no hard and fast rules for splitting the hospital into clinical directorates. The size of the hospital and total number of consultants and the numbers of consultants within each specialty are factors which have to be taken into account. As one UGM now academic said about introducing clinical directorates,

"They are not to be applied mechanistically but within their own cultures."

The ideal seems to be to produce groupings of similar specialities with roughly some equality of size. A major centre with a large specialist unit would probably have separate directorates for those units, but directorates of more than about fourteen or fifteen consultants are probably too large, whereas those with less than a half a dozen, too small. A useful rule of thumb is that medical and support service directorates can be larger than these figures as they usually contain less disparate groupings. The activity and control of the surgical specialities where services and activities are somewhat different has a far greater effect on hospital income.

There are no hard and fast rules. There are differences and anomalies. Directorates of only one consultant do exist alongside other directorates in the same hospital with more than fourteen consultants. These anomalies appear to exist for reasons of personality and history and lack of management control. There are many hospitals which for local reasons have managed their directorate structures in differing ways, for instance where hospitals are split between two or more sites. In such circumstances certain specialities, even though relatively small in their own Specialist Hospital or site, may have their own Directorate as a result.

15.3. Clinical Subdirectorates

Large hospitals with perhaps two hundred consultants may have more than thirty [sub] Directorates although these are grouped into about six or eight Clinical Directorates with the remainder as Associate Clinical Directorates, the Clinical Directors of the Associate or Sub Directorates being responsible for running them in exactly the same way, except that those (Associate) Clinical Directors do not sit on the Management Board, but meet regularly with their particular Clinical Director, their spokesman who negotiates for them on the Board, although he is not their representative.

15.4. Clinical Director: Elected or Selected?

There are important differences between these two things and it is an issue underlying a number of problems that have surfaced in discussions. As Jaques says (1978:330),

> "Elected representatives must be distinguished from individuals who are appointed by some external agency to advisory or executive bodies because they are typical of the group from which they come."

As a medically qualified Chief Executive pointed out:

> "The representative can have more problems with, and complaints from, his colleagues in difficult decisions because he is a representative rather than an appointee as the basis of the roles are different."

It might of course be possible to have every faculty, speciality and department or cost centre represented on the Management Board and this would produce a very flat management structure. It does however cause some confusion in the minds of those Clinical Directors who view their role, as representatives of their department, as continuing to exhibit tribalistic, departmental attitudes, whereas they should be exhibiting corporate and visionary attitudes.

In one hospital in this study which contained twenty four directorates twenty three of those clinical directors felt their role was to represent of their colleagues and their department. The Clinical Directors attitudes can be

summarised by the following comments of five different consultants:

"I put my department's point of view."

"To make sure my department doesn't lose out."

"To make sure other departments are not fobbing my department off."

"To gain a sympathetic hearing from my colleagues for the problems of my department."

"To represent my department and enable it to get the support of others."

Interestingly this hospital had centralized management. On the other hand some Clinical Directors in other hospitals, which were very devolved, did recognize that their role was not as representative as the following two quotes illustrate:

"Then you are beginning to move towards Clinical Directorates, when I think the roles change because you are not just representing yourself or your own specialty but you are having to speak on behalf of other people, and absorb the interests of other groups and their intentions and take on board the five year plans of others and try and mesh them into a larger organization."

"The role of consultants in this directorate is to combine with all the various directorates to make the best use of resources."

15.5.0. Some Pitfalls of Setting up Clinical Directorates

15.5.1. Failure to Decentralize

The biggest pitfall seems to be a system where the old Cogwheel Division system of the hospital remains unchanged but the titles of the various leaders and heads are changed. For instance the Head of Department becomes the Clinical Director, and the General Manager becomes the Chief Executive. In such an event there is the illusion of change, but disappointment when hoped for improvements do not occur. One ex Clinical Director and Manager who was widely recognised for his expertise on the subject told me:

> "They are only too glad these hospital Unit General Managers, or District General Managers to stamp Clinical Director on somebody's back and then forget about them, and it will just not work."

Such a system appreared in one of my study hospitals with many Clinical Directorates having no representation on the Management Board and no structure for direct communication with that Board. The Clinical Directors in such a system felt that they still carried a representative role rather than a corporate role.

Interestingly one of the smallest hospitals studied, which had also not devolved clinical management, still worked a sort of pre 1983 consensus management system,

although it had appointed people to a post 1989 type structure, preferring to call its Clinical Directors, Clinical Chairmen. Yet in spite of that, one of their Clinical Chairmen did recognise his corporate role. He stated:

> "The task of the department is to work in association with all the various disciplines to make the best use of resources for the benefit, not only of the patients but also of the staff. If one makes good use of the resources, then one is going to have spare money to improve things."

It is not therefore the structure or the hospital environment which necessarily determines the attitudes of the consultant to his management role. But the enlightened attitude of one Clinical Chairman is no match for the majority view of the failure to decentralize, as he went on:

> "Unfortunately most of the doctors involved in management and wanting to be involved in management have been those who want to build their own empires. We have a perfect example here where we need a pathology department update, and the Pathologist who is a super person insists he wants virtually everything new. Histology, haematology, microbiology, chemical pathology etc. He sees nothing else in the rest of the hospital, and some of us are saying well we do need a microbiology department, and let us just stick with that for the moment, that would do first."

15.5.2. Confusion over Roles

In all the hospitals where this failure to decentralize occurred there was also confusion over what structure and

what committee had a management role and could make decisions and which were talking shops, to air their problems. At one Medical Executive meeting made up of all the Clinical Directors, the Medical Director who was chairman wanted to refer an item concerning operational policy for a decision to the Medical Staff Committee, a body of all Consultants in the hospital, until it was pointed out by the Chief Executive that the Medical Staff Committee (MSC) had no management role, whereas the Medical Executive Committee (MEC) should have. During the time I studied this committee no decision was ever taken over any problem or issue. Another medically qualified ex Unit General Manager:

> "Never set up a structure without knowing about who makes decisions and on what. You must fully understand the organization you are putting in place: if you are then faced with difficulties you will understand how to cope with these."

An academic put it like this:

> "The means of approaching problems should be clear even if the solution is not."

Chantler (1992a) sets out four points that he considers important to the introduction of clinical directorates:

A. Professional and management accountability are discrete and should not be confused.

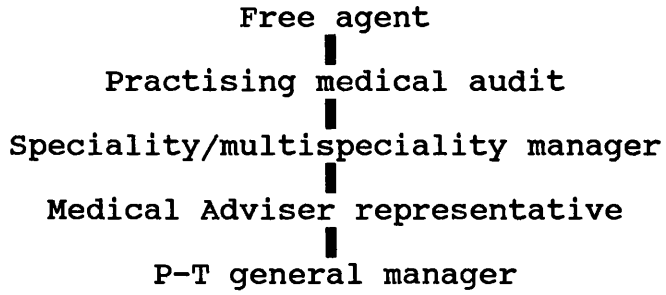
B. Decentralisation should be encouraged to produce a broad and flat management structure for operational purposes with clear definition of responsibilities and authority (which must be commensurate) and accountability.

C. Management commitment of the professionals involved in general management at clinical directorate level should be part-time so that they can continue to fulfil their professional responsibilities. To be successful teamwork must be encouraged and the leadership of the team does not need to be defined in advance but does need to be determined.

D. Adequate information systems should be introduced and these should be determined by the clinical needs which should have primacy as well as the management requirements.

15.6.0. Some Different Models of Clinical Directorates

The range of model found in the U.K. and indeed American Hospitals is almost infinite between two extremes of a spectrum. Mumford (1989) desribes a typology of roles along a contiuum:



Although Fitzgerald et al (1992) feel this useful in showing the different perspectives on patient, financial responsibilities and the sphere of interest they point out that it does not explicate the issues of accountability. However as I have shown in Chapter 3 Section 7.4 agreement, responsibility or authority are more important factors in the continuum. They are issues which I shall discuss in detail in the next chapter. There are other flaws in Mumfords model, not least that medical audit is educational rather than managerial (DHSS, 1989. SCOPME, 1990. and Batstone, 1992).

15.6.1. The Traditional Two Models View

A. True Manager

At the one extreme is the true manager, the Clinical Director, Chief, Chairman, Director of Faculty (the terms vary) the clinician leader of a care group or speciality and half manager, half clinician. Regional Medical Officer:

> "A manager of a unit or department who is allocated or negotiates a budget, with senior management and is responsible for spending that budget. He has two

> contracts, one a contract as a clinical consultant, the other as a manager. He is therefore, properly placed in general line management, bound by the ethos of being a manager. He may manage staff other than his own immediate junior staff, nurses for example, although professionally they remain accountable to the Senior Nursing Officer."

It is a part time activity as they are generally practicing clinicians. The quality of their support staff is vital. One Chief Executive described their role as follows:

> "These Directors are responsible and accountable for the planning of the service, allocation of the resources and all operational work including the specification of internal contracts, taking responsibility for service planning and service development and working alongside a speciality manager, responsible for daily operational management. The clinical director is at the heart of the process and is the key decision maker. This draws the clinician into corporate responsibility, accountability and influence."

The difficulty lies in combining the time consuming management responsibility with a clinical practice. There are problems of time and motivation to say nothing of the cost to the service of the loss of "hands on clinical work". At present there are few clinicians in this type of role. There appear to be two main reasons given for this: firstly that there are few clinicians with the necessary management expertise for the role, and secondly there are few who wish to undertake such a role.

B. The Chairman

At the other extreme is the position previously known as the Chairman of Division, a representative who has been labelled a Clinical Director but for whom nothing else has changed. A Regional Medical Officer described the role in this way:

> "Here a speciality manager agrees activity targets between the U.G.M. or C.E.O. and the clinicians. The speciality is then provided with full management support by the speciality manager, the budget holder. Management responsibility lies with the full time manager and clinicians concentrate on clinical work, where they remain on the periphery and consequently are less directly accountable. Managers in this situation are much more at the point of managing professionals directly."

There is support for this view of two distinct models from The Institute of Health Services Management (Disken et al, 1990); they describe the differing clinical management structures at six Resource Management Initiative (RMI) sites as also clustering around two distinct models.

The first is the traditional model where a consultant is elected as chairman of a clinical division; a medical advisory structure produces medical representatives for the management board and nurses, therapists, technicians, etc., are managed in their own hierarchies. And the second is the directorate model where the Clinical Director is accountable to the U.G.M. and sits on a management board; medical representatives are no longer

involved in the management board and nurses and other core staff in each clinical service are managed by the clinical director who holds the budget. They also see these models as at opposite ends of a spectrum. These authors did not find a unit showing a pure version of either although as the work was published in January 1990 this was very early into the latest reforms.

15.6.2. Three Models View

Moore-Smith (1992) describes three organisational models of clinical management based on the work of Disken et al (1990).

A. The Consultant Co-ordinator

This is the old style hospital management with no devolvement of responsibility or authority.

The UGM retains control and accountability for professional and managerial hierarchies.

The Consultant coordinates and monitors colleagues.

The Consultant does not hold the budget.

The Consultant is not responsible for the management or performance of other team members.

Teams are not corporate and not accountable for budget or performance of group.

B. The Clinical General Manager

The operational management of clinical services is delegated to clinical managers who may be from any professional background.

Medical/management relationships are conducted through medical representatives but there is no explicit contract between consultants and managers.

C. The Consultant Manager

Operational management of the Clinical Service Team is highly decentralised.

The UGM is in contract with the Consultant Manager who coordinates colleagues and other medical staff.

The Consultant holds the budget for staff and services within unit.

The Consultant is responsible for day to day management, recruitment and selection, staff appraisal and staff development.

The UGM is no longer a manager but negotiator and coordinator of clinical contracts.

Moore-Smith (1992) regards each of these models as a stage in the development of the role of clinicians in management. The Consultant Co-ordinator is the old style of hospital management with no devolvement of ownership or responsibility. The Clinical General Manager he regards as an "idealist" solution, and presumes a massive shift in cultural attitudes within the hospital and within individual professions. The Consultant Manager is the classic Clinical Director model where the directorate is managed by the Clinical Service Team of Clinical Director (Consultant), Nurse Manager and Business Manager.

15.6.3. Chairman or Clinical Director

Before considering various models it might be helpful to consider the characteristic organizational features of the traditional model, where the consultant is co-ordinating head or Chairman of a team or department:

Individual consultants prescribe treatment and care for their patients.

The Chairman is elected from the consultants within the faculty or division.

All the Chairmen sit on a Medical Executive Committee.

The Chairman of that committee is elected by that committee.

That elected Chairman sits on the Management Board.

Nurses and other professional groups are managed within their own separate hierarchies, and each has separate functional budgets.

Sometimes the Chairman of the M.E.C. might be a senior consultant who was not a Chairman of a division or faculty but who had been appointed by a caucus of senior consultants within the hospital.

The Clinical Director model differs in a number of important ways.

The Clinical Director is accountable to either the Unit General Manager or Chief Executive or the Medical Director.

The Clinical Director holds the authority for the budget, and is responsible and accountable for the service.

Medical representatives of each and every faculty or division may no longer be represented on the Management Board.

The nurses and other core staff in each clinical service are managed by the Clinical Director, but professional accountability remains distinct.

At the beginning of this study the pure form of the true directorate was rarely seen, but it is becoming increasingly common. Most Clinical Directors did not feel accountable to the Unit General Manager or Chief Executive although the same Unit General Manager or Chief Executive usually felt that the Clinical Directors were accountable to them. The fact was that doctors tended to feel more comfortable when reporting to another doctor and for this reason it may be desirable that a Clinical Director should report to the Medical Director rather than the General Manager or Chief Executive but more Clinical Directors are now openly accepting that they are directly accountable to the Chief Executive.

It might be appropriate to state that the Clinical Director does not necessarily have to be a consultant,

but could be another senior professional within a department. Ross (1992) stated:

> "The most suitable person should be the Clinical Director, not necessarily a doctor".

15.7. Specific Examples

Some specific models have been published and achieved fame, particularly as they are often quoted as a model by which a particular hospital works although often this may not be an accurate picture of the structure working within that hospital.

A. The Johns Hopkins Model

Here each functional unit is headed by a Functional Unit Director (clinician). Reporting directly to each is a nursing director and an administrator, the three working together as a Management Team. They are accountable for all direct costs associated with the operation of the unit, including services from other departments, such as laboratory, medicine and radiology. Costs that pertain to the operation of the institution as a whole e.g. central personnel administration, security, accounting, billing and insurance are allocated to the functional unit. Each unit may use services such as housekeeping, dietary and maintenance, from central hospital departments, but the unit may also switch to other

providers. Each functional unit has of course to operate within the general policies of the hospital. It was felt that management strategies directed by physician managers were more likely to be successful as they could influence the behaviour of their colleagues.

B. The Guy's Hospital Model

The experiment in decentralized management at Guy's is succinctly described by Chantler (1992b):

> "A group of clinicians had been watching with interest the experiment of involving clinicians in a decentralised operational management structure for a hospital conducted at the Johns Hopkins Hospital, Baltimore after 1972. They persuaded the district management team to visit the Hopkins and they too were impressed with what they saw. It was therefore agreed that an experiment would be started in April 1985 to introduce a similar management structure to Guy's. The essential nature of the contract was that the clinicians would take a dominant responsibility for the operational management of Guy's and in return for the authority to influence the allocation of resources they would accept responsibility and accountability. This accountability included acceptance of financial accountability."

Thirteen clinical directorates were established, (this has since been increased to twenty four), each being headed by a clinician assisted by a nurse manager and a business manager; Chantler (1991). The business managers were mostly chosen from professional hospital administrators but could be nurses or other professionals such as scientific officers. Some directorates share a

business manager. Management accountability is seen as very distinct from professional accountability.

Clinical Directors were not elected but appointed, on advice from colleagues, with regard however to their management capabilities, as seen by the Chairman of the board and the District General Manager.

Responsibility was then decentralized to the directorates so that over 60% of total staff report within the directorates. These comprised doctors, nurses, clerical and scientific staff, etc. Centralised outpatient appointment and management arrangements, admissions, management of waiting lists, were dismantled, the responsibility being assumed by the individual directorates. Rules for bed borrowing were also established and the authority of the ward sister over the ward was re-introduced, including management of the ward budget. Chantler (1992a) says that the Guy's system initiated in 1985 continues to evolve.

C. The British Medical Association Model

In describing what it saw as the clinical directorate model the BMA (1990) stated that:

> " Although the ultimate managerial responsibility for a unit lies with the accountable officer, the executive responsibility for the management, finances and other resources of the unit should be carried by a single

management body which contains a significant number of senior medical staff as full members."

The BMA model has a single management body on which all clinical directors sit as full members, this body having full executive authority for the management of the units including finances and resources. Clinical Directors elected by consultants in that speciality are responsible for certain personnel and peer review matters, such as medical audit, but cannot over ride the clinical judgement of colleagues. This does have difficulties if there are large numbers of Clinical Directors sitting on the management board because of the difficulty of handling large meetings requiring decisions, in addition to the possible difficulty caused by Clinical Directors being elected by their colleagues, to act as their representatives.

15.8. Basic Principles of Clinical Directorates

Certain principles seem necessary if clinicians are to be properly and genuinely involved in management. As a Clinical Director described:

"This includes decentralization of authority and responsibility and the development of team work between different professional groups. It is important that the management skills of the other groups, the business managers and nurse managers, are also developed."

A Regional Director of Public Health felt that it was vital that the Clinical Director did not remain as a Chairman with a new title and no authority:

> "but ending up as a glorified middle manager taking the responsibility for reductions in services together with all the budget restrictions. This may well curb clinicians if they have a management contract for the general management component of their work since they can be instructed to do certain things as manager, which they would never contemplate as a clinician. This would be a middle management role that does not effect the allocation of resources."

This was initially a common phenomenon and is a picture of a Clinical Director, really little more than the old style Cogwheel Chairman, representative of his colleagues. As a medically qualified academic put it:

> "He is not part of the management chain but has alongside him, a Business Manager, part of that management chain and who between them manage the unit."

The Clinical Director here does not carry budget responsibility, is not part of line management, but is the doctor representative of colleagues, negotiating with the Manager. The only new feature in this organization is that the management structure is allied to the clinical structure.

15.9. Some Concerns about Clinical Directorates

Kennedy (1990) raises concern that there may be serious flaws in the Clinical Directorate model, ultimately

making it unworkable for consultants and bad for nurses and others. He challenges the Clinical Directorate concept by asking a number of questions about the management responsibilities of the consultants, whether Clinical Directors can successfully direct consultant colleagues and whether there is true representation. But as I have stated previously most authorities do not regard a Clinical Director as a representative in the way that the Chairman of a Division was a representative, because for instance he is not elected by his colleagues and takes a corporate rather than a departmental view.

Neither is a Clinical Director a director in the sense of ordering people, particularly his colleagues, how to treat patients etc., hence the dislike of the term by some hospitals and consultants. Some still label the role "Chairman", others "Consultant in Administrative Charge", others "Head of the Department". Whatever the actual title, this is less important than the functions. What is important is that a review and evaluation of a departmental organization should focus on the roles of the Clinical Director, Business Manager and Nurse Manager as a Clinical Management Team. Such a review should include consideration of the following, a summary of some of the main views of several Clinical Directors with some inevitable overlap:

Is there proper delegation of authority from the Chief Executive?

Is there proper responsibility, accountability and authority?

Is the Clinical Director properly supported to make best use of his skills and time?

Are colleagues in the department aware of the implications for the hospital of the decisions it makes?

Is there collaboration, cooperation and working as a team?

Are decisions being made at the level of impact?

Are initiative, innovation and risk taking encouraged or suppressed?

Is proper training given in health service organization, accountancy and information technology?

Is there proper recognition given to the work regarding remuneration and a career structure?

15.10. Conclusions

There is no holy grail for a structure to run a successful hospital, but if the clinical directorate model is chosen then as one Clinical Director put it,

> "The Clinical Director does need to lead the directorate, take a role in hospital planning, be an ambassador at corporate level and involve the body of consultants in the management process. There also needs to be a changing of mind sets and boundaries by some of the people involved both clinicians and managers."

The change in culture and the time scale necessary for this was highlighted by one of the American Managers:

> "It is easy to change the structure but it takes longer to change the culture. You may not expect to see any change in say two years."

Once the decision has been made in principle to implement an organizational management structure based on clinical directorates it is appears to be essential to dismantle all existing representative and advisory machinery.

General Manager:

> "A bureaucracy is very difficult to dismantle, the bureaucrats within it resist. Districts and Regions hang on to power."

And a Medical Director commenting similarly on the need to dismantle old structures before using new ones added:

"Without this, old parallel structures with management roles tend to subvert the new structure. There continues to be a need for a forum for all consultants to discuss matters of interest and importance to them, reflect views etc., such as a Medical Staff Committee but it is important not be part of the managerial structure and have no explicit or implicit managerial role. It is not possible to run an old Cogwheel Divisional system alongside or mixed with a Clinical Directorate system."

It is important that the Clinical Directors meet with their directorate and all the hospitals within this study do this monthly. The staff committees, often known as the Medical Staff Committee, are important in an open organization, but they have no role in the management structure and the managers and consultants in this study universally recognise this.

There is one other change, important when considering the switch from a divisional system to a clinical directorate system. The former was doctor dominated and had no involvement with the nurses and other professionals except as observers. The clinical directorate system works with nurse managers, business managers and heads of departments and discusses business matters relating to the directorate. Indeed some took the view that the change in "business" may require a re-definition of clinical freedom. This reintroduced the subject of whether doctors should involve themselves in management. The Clinical Director of one major hospital felt very strongly that the new clinical directorate structures

would enhance clinical freedom rather than curtail it, a view supported by a number of Clinical Directors:

> "Because clinical freedom is limited by the laws of society, good professional practices and ultimately funding, involvement of doctors in management by assisting in preventing waste of resources enhances the clinical freedom for the use of available resources."

Another Clinical Director:

> "Because of the aging population, new scientific advances, new technology and limited resources it would be unethical for us not to get involved in management, at all levels. No one else can make some of the difficult decisions. They may need to be shared decisions, but they need medical advice. And in so doing it ensures our continued clinical freedom."

And another Clinical Director:

> "I think we have an ethical duty to make sure that resources are used in the most effective way."

It was best summed up by one ex-Clinical Director who had experience in the past of management as a UGM:

> "Firstly it would be unethical not to be involved. There is an aging population with chronic degenerative disorders. Scientific and technological change tends to be led by publicity and funding. Doctors have to be involved, it would be unethical not to be. And I think it guarantees maximum clinical freedom."

In the next chapter I will consider some of the problems and difficulties, how they can arise and how they are being addressed.

CHAPTER 16

CONCEPTS IN CLINICAL MANAGEMENT

16.0. Introduction

Making decisions in a sensible way is a human function; however when those decisions involve other people it may require management skills. Taking action is also a human activity, but when it involves other people it can be more efficient and more effective if management skills are used. I can find no universally accepted definition of a manager, management or the management process. Nor it seems am I alone in this. Heirs and Farrell (1989) discussing management and managers:

> "It seems so often to mean different things to people in different professions, or even to different organizations within the same profession. Unfortunately, there are no satisfactory substitutes."

For them however a manager is

> "an individual who has responsibility for making major decisions and for determining policy and plans within any organization."

According to Drucker (1968:19),

> "The first definition of management is therefore that it is an economic organ, indeed the specifically economic organ of an industrial society. Every act, every decision, every deliberation of management has as its first dimension an economic dimension."

Boyatzis (1982) seems more helpful;

> "A person in a management job contributes to the achievement of organizational goals through planning, coordination, supervision, and decision making regarding the investment and use of corporate human resources."

Appley (1969) agrees that a manager is someone who

> "gets things done through other people."

Handy (1985) in discussing the problem, suggests that if it is a problem it is one of roles. Almost any manager has an array of roles to choose from. This he feels can result in a feeling of role overload and stress, or it can be a licence to play all the parts in an ever-changing drama. All this is a reference to Mintzberg (1973) who describes ten roles for a manager although this work was based on the observations of five chief executives. Other managerial jobs may not be so wide or so complicated, and Stewart (1983) has based work on a much wider field at lower and middle levels, the latter of which are probably more comparable to the operational role of the Clinical Director.

16.1. Managing and Doctors

Interestingly Handy (1985:365) draws a medical analogy with the manager as a General Practitioner:

"The analogy of General Practitioner has been hauled in from the medical world to characterize one role that is not emphasized by Mintzberg but underlies all the other ten roles. The manager, like the GP, is the first recipient of problems. However he may deal with them, whatever role he may choose to assume, he must first (like the doctor) decide whether it is a problem and, if so, what sort of problem it is, before he proceeds to act. He must in other words: Identify the symptoms in any situation; diagnose the disease or cause of the trouble; decide how it might be dealt with - a strategy for health; start the treatment."

It is therefore not an exact science and for that reason often does not appeal to a doctor's basic instincts and scientific training. The search for universal principles is frustrating. Management is an art with a science base. (In the same way that Russell (1958) describes history as both a science and an art.) It has generally to be learnt by experience. Being complex it is interpreted differently by different people. The manager is concerned with setting goals and achieving objectives. The effective manager is many things, a historian learning from past success and failures, a psychologist who must understand the way people act in, and react to, group situations, and an innovator who can develop new ways to achieve desired objectives and apply them in an appropriate manner.

Health service organizations are frequently said to be unique in a number of ways, so management study and practice has to take account of that uniqueness. These unique features include: the absolute necessity for high

quality of work, the involvement of high technology, the use of a wide range of human resources, the co existence of automated and manual work methods, many separate professional groups etc. some features of which may be found in other organizations, but the most unique feature is doctors' professional clinical freedom.

16.2. Managing after the Reforms

The idea behind clinical directorates is that everyone engaged in an enterprise should be involved with the management of it. This concept was the foundation to the introduction of general management into the health service in 1983 (Griffith, 1983). It has already been emphasised that when Griffiths recommended general management he claims that he did not intend that a new profession of managers should be created within the NHS, but rather that all staff, doctors, nurses, administrators and others should contribute to the management of the service.

Clinical directorates are based on the concept of team work between all staff and to be successful depend on breaking down the professional barriers. The carrot of the 1989 reforms was that with less bureaucracy decisions should be made quicker. Significant service developments and initiatives should be achievable in a surprisingly short time. Long standing minor but persistent

irritations should be swept aside. Long term conflicts of interest are brought to a head and resolved. As two managers put it,

> "The clinical directorate system is the latest organizational response in a line of initiatives designed to encourage clinicians to take greater responsibility for the delivery of healthcare and the use of resources by being involved in the decision making process, and which will also speed up those decision making processes."

> "The recent NHS reforms and the development of the market encourages more explicit discussion of choices in the allocation of scarce resources and a greater linkage between expressed need and provider response as well as a more immediate response to needs expressed."

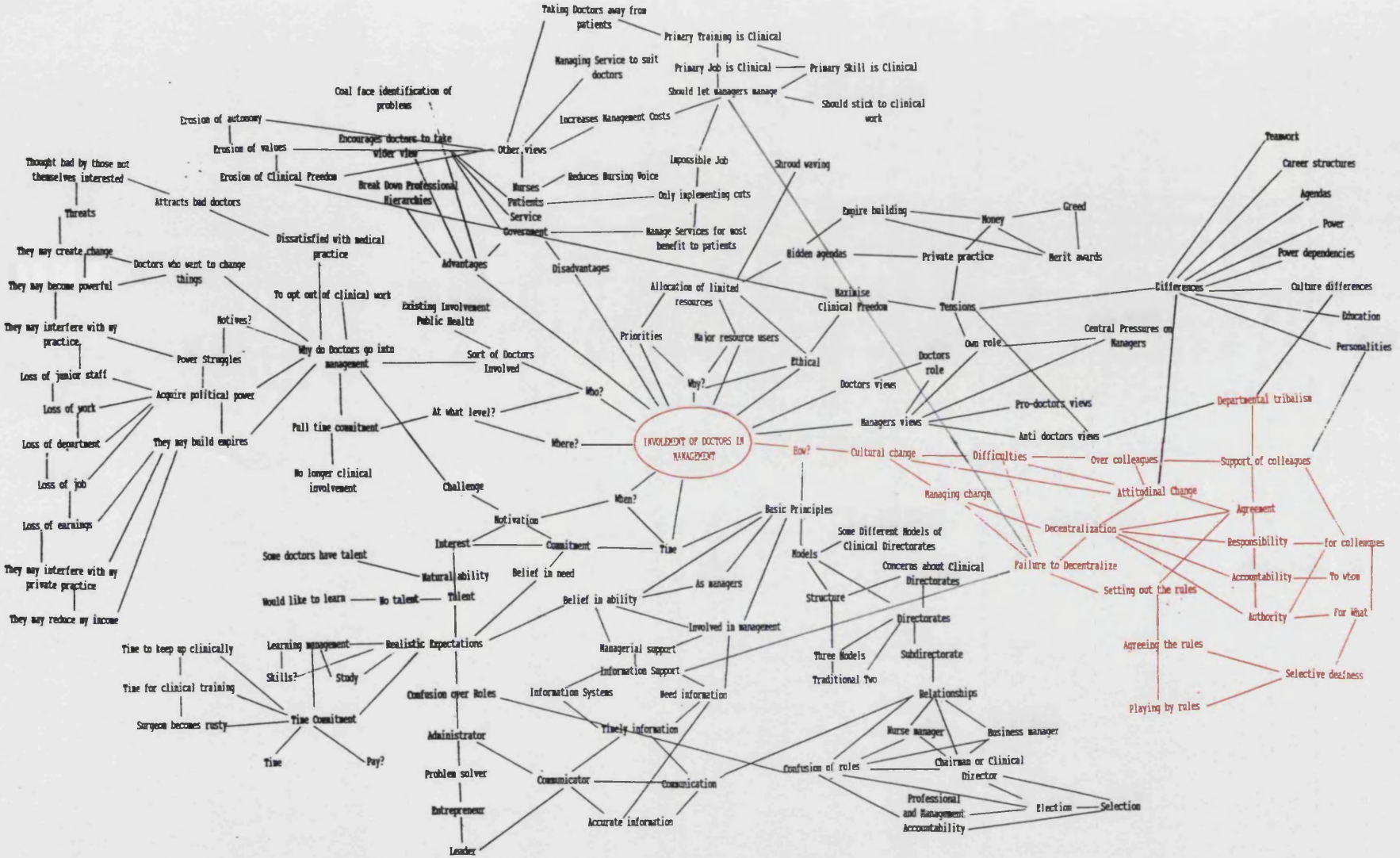
As the final version of the cognitive map shown overleaf on page 421 shows, certain characteristics and concepts are important.

16.3. Agreement

Several participants stressed that without the agreement of all the parties, Clinical Directors, UGM, DGM or CE, and the Consultants and others within a clinical directorate, the system will not work. UGM:

> "Unless there is agreement on the size of the budget and the service to be delivered, there cannot be responsibility, accountability or authority."

And a Clinical Director;



COGNITIVE MAP CHAPTER 16
HOW CHARACTERISTICS AND CONCEPTS ARE IMPORTANT

"Eventually we got agreement on these issues of responsibility, authority and accountability. Fights still took place, but they were much more sensible fights, everyone knows how the system functions and they are fights directed at improving the service as a whole."

16.4.Responsibility

I was also told that the definition of roles and general responsibilities seems to be relatively easy to agree.

The BMA (1990) states that individual consultants still have continuing responsibility for their patients, although that clinical freedom is subject to the limits of law, ethics, contracts, professional standards and resources so that Clinical Directors could not commit colleagues to workload or resource agreements, discipline or sanction colleagues, or override colleagues' clinical judgement. The Clinical Director should of course be able to negotiate on behalf of consultants agreed workloads, and monitor that agreement. He can co-ordinate medical personnel matters, peer review and audit. And none of this precludes any consultant still talking directly to management about their own practice. And there appears to be no disagreement on these matters. All the Clinical Directors I studied were comfortable with this and did not admit to experiencing any problem with this. However the study did not include any attempt at an intra directorate study, an issue I shall return to in the chapter on directions for further work.

As far as the directorate was concerned it seemed important to identify and agree on what they are responsible for. Again the BMA/CCSC (1990) view is that budgetary authority and responsibility should be for staff i.e. medical, nursing, secretarial, administrative and other professionals and non staff i.e. medical and surgical equipment and drugs, ward supplies etc. But this actually depends on the role model chosen and local decisions and agreements. For instance in one fully decentralized unit the Clinical Director and Managers were agreed that:

> "The clinicians would take a dominant responsibility for operational management and in return for the authority to influence the allocation of resources they would accept responsibility and accountability."

> "Clinical Directors would be responsible for running the directorate on a day to day basis and to deliver the agreed services within the budget."

In a hospital not decentralized the managers and clinicians did not seem to agree about responsibility. The Chief Executive felt that:

> "The Clinical Directors are responsible for everything within the directorate, the finances, negotiating the budget, ensuring it all balances, getting the work done, achieving targets but making sure they do not do more work than our purchasers buy from us. Quality issues, finding Extra Contractual Referrals (ECRs) and extra work from Fund Holders."

Yet of the Clinical Directors in that same hospital sixteen felt they had little or no responsibility over those issues. A typical comment was:

> "Being Clinical Director is little more than having a name, I have no more influence than any of the other consultants."

Although another did feel it gave him some influence over his colleagues:

> "I don't have any budget. But I regard myself responsible for appointing them [colleagues] and making sure there's somebody there [in the department], and looking after them and moving up the line and all the rest, and for looking after the junior staff not only in my department but also in the A & E Dept which I am theoretically in charge of, but in practice, because we don't have an A & E Consultant."

But responsibility to whom seems to be less clear The British Medical Association CCSC (1990) state unequivocally:

> "Clinical directors should be managerially responsible to the management body."

But also to be considered are the Faculty, the Unit, the Directorate itself and the Speciality. The Clinical Director should be responsible directly to the Chief Executive or UGM, but frequently the Clinical Director reports to the Medical Director, as representative of the Chief Executive. This is because doctors usually feel

more comfortable reporting to another doctor. (White 1993).

The question of loyalty and responsibility was also raised and whether they are the same or different and indeed how different they might be. Responsibility implied being accountable. But did loyalty mean adopting hospital policy and accepting the constraints of management like mindless conformity or should it mean doing what one thinks is best for the organization in the long term? Kanter (1989) offers a theory that in post entrepreneurial organizations there is the prospect of a different definition of loyalty:

> "there is often no such thing as a "chain" of command, and people work under different leadership for different purposes.....There is encouragement for people to test limits, challenge traditions and move in new directions..... Decentralization of decision making responsibility puts more power in the hands of people at lower levels to make decisions and exercise judgement..... Professionalism.....transcends the organization..... Post entrepreneurial organizations produce so much change that they cannot offer the same incentive for unquestioning obedience."

16.5. Accountability.

Together with responsibility and authority comes accountability. Accountability means seeking better financial information, heightened budgetary awareness, and performance more closely monitored. This new responsibility requires accountability, accountability

not only for the level and quality of service but also to the production of data which demonstrates and confirms this. Clinical audit and quality management suddenly become relevant and continuous multi-disciplinary activities. Because standards are largely determined by doctors themselves, they are understood, owned, relevant and achievable. Two Clinical Directors said:

> "Suddenly I was accountable for all this, so I had to know what was going on, I had to be able to see where I was, how we were doing, and I also needed to be able to show that I was doing it right."

> "In the old days most of the information was wrong, now we collect it ourselves here in the department, I know exactly what the situation is virtually from day to day, and I know exactly how we are doing. I tell them what is happening, not the other way round."

16.6. Authority.

Many Managers and Chief Executives balked at the thought of giving doctors authority. They frequently talked of authority only as "hire and fire" and did not see any wider context, how Clinical Directors exercised authority over and gained acceptance by clinical colleagues, how Clinical Directors influenced the behaviour and clinical work of colleagues, and how they achieved this.

Talking to doctors about authority I obtained a somewhat different view; they mostly thought of authority to persuade and encourage their colleagues in a directorate,

to do what was asked and required of them. But authority for a Clinical Director seems to be more than that. They do not need what the managers consider authority to be, and they should not need to be given authority over their colleagues. To some extent those colleagues have already put themselves into a quasi submissive role by accepting him as their director or agreeing to his acting in that role. Consultants:

> "He is the Clinical Director, I accept that although I didn't appoint him. We are all happy with the arrangement however."

> "I didn't want him to be Clinical Director but he is, and it seems to work, and I'm happy to go along with the system."

As a result of some of the feedback sessions from Clinical Directors and Managers the one issue which seemed to cause most difficulty and confusion, even to what it meant in this context, was this question of authority. And it was in those hospitals which were still centralised that this was a difficult issue to resolve. One Chief Executive said:

> "I am not sure what is meant by authority. Clinical Directors say they need some authority, but authority to do what. Do they mean to hire and fire? I mean I have no authority."

> "I can't give authority to consultants, because I don't know what it means. Does it mean that they should be able to fire people?"

And a Chairman of a Trust Board:

> "You cannot give people authority, it is something they have or they take."

Other UGMs and DGMs in centralized units:

> "Authority in a sense is very difficult to define. Some have got it, some haven't."

> "Authority are sorts of sanctions, difficult to prescribe in a way; the sanctions can be very differently used, by different people, as we're all human. With different shades and ability you and I could be both given the same authority, sanctions authority, and you could use them better than I or vice versa. And sometimes you use sanctions that you wouldn't dare want to write down."

> "I would use blackmail. Now that isn't an authority, it is abuse if you like of authority, but you would use all sorts of things."

> "I mean, authority is in a sense discipline of dismissal, and is a very last resort."

> "But what authority is appropriate authority, for what we want doing really. I see the financial incentive of saying you can't have your budget or you can't have that piece of equipment. They're some of the things I'd try on in terms of use of authority. You'd have to negotiate authority, just as you do as in dealing with a child where you haven't absolute authority."

To fulfil the duties of Clinical Director I was particularly interested to know what degree of authority needs to be vested in that individual. I found answers to these questions much more clearly stated in decentralized units. Some Clinical Directors:

"For clinical directorates to work responsibility and authority must be co-terminous and commensurate."

"The attitude of the District Health Authority and the then District General Manager was that he was prepared to de-centralize responsibility and authority to the doctors."

"What we got was the authority to run the place and to actually determine the allocation of resources within the hospital."

"Everyone agreed that we had to have the authority to run things but with that came responsibility and of course accountability."

And Managers:

"Doctors have to be involved in making those choices, and they know that they cannot expect to be involved, unless they accept responsibility as well as authority."

"So one of the three crucial features that I think have to be satisfied when you involve professionals in the management of any service is that responsibility and authority have to be de-centralized in equal measure and accountability has to be clear."

"There has to be clear accountability, but that's also got to be clear authority and responsibility."

And there was recognition even in the successfully decentralized units that this issue had been a problem.

Medically qualified ex UGM:

"Managers seemed to be very reluctant to give up authority. Now we've had that in this place. I mean I had a huge battle in the first year of my time here, in persuading the central administration to let us do what we wanted to do. I mean it was overt opposition to begin with, and then it was covert opposition thereafter."

So although there were some, both doctors and managers, in decentralized units with clear ideas on these issues many doctors and UGM/CEO's appear to exhibit considerable confusion over the authority required by a clinical director to undertake the role.

Morgan (1986) exploring the nature of power and how it influences who gets what when and how, lists a number of sources of power of which formal authority is the first and most obvious source. This is what Weber (1947) describes as a form of legitimized power. Historically it is underpinned by one or more of the three characteristics: charisma, tradition and the rule of law.

Charismatic authority occurs when people respect the individual and personal influence, especially over opinion, comes from that respect. The rational-legal or bureaucratic authority arises when the exercise of power depends on the application of formal rules and procedures and most obviously occurs when the power comes from the holding of the formal position or office.

Despite a lack of managerial line authority some clinicians have considerable success in managing their colleagues. The processes that successful ones use are based on representing, involving, consulting, trading, using personal power, the skilful use of information and

often the ability to fit their work into a broader picture.

One CE felt that there were three approaches with personal influence the most important. He called them the good, the bad and the sensible.

The good was the Christian way, dealing with brotherhood, love and trust; The bad, the machiavellian, wheeling and dealing, scheming, fixing, politicking and the knife in the back; And the sensible was the logical way, using facts, logic and sensible and rational argument.

> "A clinical director will need to have all these cards in his hand, and he may well have a natural tendency to play one more than another, but what is important is knowing when each should be played i.e. savoir-faire."

16.7. Decentralization

Not all the tasks required of a Clinical Director fall into one of the above categories and it is here that problems arise when management boards expect results which Clinical Directors cannot deliver, when the board thinks that all is required to produce action and change is more accountability, but decentralization has not occurred. I was given the following examples, the first concerning inpatients:

A surgeon was asked by the management to arrange for his directorate to carry out a contract to perform a number of extra elective operations. The members of the directorate were willing to do that. But there proved to be a number of stumbling blocks. The directorate did not have the time within the week, did not have the beds available, and did not have theatre time. In addition there was no available anaesthetist, because they were part of a different directorate.

The Manager could not understand why there was a problem; he said that full responsibility had been given to the Clinical Directors. The Clinical Director felt that he was doing all he could to get the work done, but was not allowed to change the existing pattern of the working week to accommodate the extra work, use other empty beds, or negotiate with another directorate. The hospital management board said that there was spare capacity in the system, as there were beds closed, but the Clinical Director was not able to use them. There was said to be spare capacity in the theatres, but the theatres were working to a budget and overspent. No one had considered the question of the authority to deal with any matter which changed existing work either within or outside the directorate. Unless a Clinical Director has authority to organize these issues, no matter how willing the directorate to carry it out, it could not be done; no matter how much he is responsible to the Chief Executive

of Medical Director, and no matter how accountable he was, nothing actually happened.

Another example concerned outpatients:

A DGH served some outlying small towns with their own outpatient clinics in the cottage hospitals. The cottage hospital had an enormous waiting list. But one of the other hospitals had so few patients for the number of clinics that rarely if ever was the clinic fully booked, and everyone was seen at the next clinic after referral. At one town there were complaints about the delays, but the Clinical Director could not change anything even though the Chief Executive said he had given full responsibility to the Clinical Director who was accountable to the management for the service, because the Clinical Director had no authority to change anything.

A third example concerned the lack of balance between inpatients and outpatients:

The number of outpatients clinics being held within a speciality was greater than the number of operating sessions that could service the number of patients requiring operation. The result was an increasing surgical waiting list. There were many complaints about

this, but the Clinical Director was not able to address the underlying problem as he had no authority to do so.

Thus to give a Clinical Director responsibility, no matter how accountable that person is, without authority "to do the job" little useful is achieved.

16.8. Departmental Tribalism.

Tribalism is a rather fashionable term that refers to groups, usually within the same profession, but it can also be used in the sense of referring to the strong identification with groupings of patients rather than a profession. In other words doctors identify with their department and speciality. They feel only secondary loyalty to the hospital. When I asked consultants what they did for a living they would invariably say " I am a urologist ," or "I am a general physician," or "I am an obstetrician and gynaecologist, " or " I am a general surgeon," or "I am an ophthalmologist," etc. They never said "I work at St X's Hospital or the Y Royal Infirmary". This does not seem to be changing.

Tribalism according to Robinson and Strong (1990:20) includes a number of characteristics:

> "it is a term used by general managers in the privacy of their own conferences - referred to some characteristic features of the health service trades; to their strikingly different culture, history and

organization; to their huge fragmentation; to their fierce internal loyalties; to their general lack of any external vision; and to the consequent difficulty, despite their very real commitment to the patient, in providing an effective, coordinated overall service."

Medical staff particularly felt more responsible for standards of care throughout their own directorate rather than exclusively those of their own profession. Typical was the view of a Clinical Director:

"So long as my department is working properly I am not too concerned about other departments or even the hospital really. Just so long as they do not rob us of resources to pay for their [other departments] inefficiency."

But some things are changing rapidly since I first started, later interviews with Clinical Directors were very much more in line with this view:

"I think there is a greater realism than there has been before, amongst, I don't know whether to say, most or just a lot, I'm not sure what the proportion is, but it is coming and it is growing and after a pretty sticky first few months while things were shaking down, I think there is now an acceptance of what is going on and sounds corny, but a corporate identity is beginning to return."

So it seems that tribalism is being confronted in the face of a more explicit shared responsibility. There is in many hospitals a more relevant participation in the running and development of the service. There is more evidence of commitment to corporate management. This entails a consciously managed process which must be seen

to erode traditional tribalism. As a Clinical Director put it,

> "It encapsulates the difficult shift from fighting one's corner to fighting for someone else's."

A manager was able to recognise medical tribalism when she said,

> "There can be confusion about the nature of the directorate roles and responsibilities and the balance of centre directorate loyalties for instance due to outbreaks of professional tribalism. This may manifest itself in withholding information, lack of support, poor communication, and lack of commitment to teamworking."

16.9. Some Dilemmas.

Doctors are able to provide long term continuity to the running of a hospital which balances the change of managers every few years. This tendency appears to lead to management thinking shorter term than had been previously been supposed. A DGM:

> "I've felt very much that administrators or managers moving every two years produces lack of continuity in management that's an important defect. They don't have to think long term, although people think they do, and they are accused by doctors sometimes of only thinking long term. It's actually not true really I don't know why it happened."

An ex UGM:

> "Doctors provide long term continuity of management to balance the constant change of managers every three or

four years. For this reason managers I am afraid do not necessarily think truly long term."

And a Clinical Director agreed:

"Managers are only here as part of a career move, so they only think short term. The only advantage is that at least if the person is no good, at least you've only got to wait two or three years or so and you'll have somebody else."

This it was recognized, might change. Clinical Director:

"Having to work to much closer with the financial limits and having to achieve contract targets, and being involved much more closely in the financial survival, if you like, of the department, could well make doctors also think much shorter term. And that might be to the detriment of the service as a whole."

The other dilemmas which need to be taken into account as Clinical Directors develop their role are the professional and organizational tensions. No longer is the Clinical Director just a clinician and equal member of a peer group, but leading a management team, while at the same time engaged in clinical activity. He is a respected clinician maybe, but now a complete beginner in management skills. Some Managers:

"They need to have the capacity to understand the problems that the staff are facing and to be able to make judgements about those problems. Management is not about having the technology or the technical skills to solve medical problems."

"You have to develop skills, other than your direct profession."

"I don't think that doctors appreciate the complexity of management. They are just beginners."

"A range of skills needs to be developed [by doctors] which can't always be developed on a part-time basis."

"Doctors are less well equipped than managerial professionals, because at the end of the day its about how they can, have they got the basic skills, the basic personality to withstand the pressures of them."

And doctors recognized their lack of management skills.

Typical comments were:

"The trouble is I know nothing about managing."

"One of the problems is that we are beginners in management, not that the managers seem much better informed, but they have more experience at it than us."

Several Clinical Directors not only indicated this but wished to be trained. Clinical Director:

"Doctors need preparation for those things; registrars and senior registrars in particular are all expected to go on management courses. They're a bit half-baked at present and a bit short, and I don't believe you can train somebody in the sort of management skills that a Clinical Director ought to have in the course of three weekends. I'm not sure you could train them at the under-graduate level, but what you could do is to create an awareness of the scope and the need but with all the other things, the pressure etc, you couldn't do very much about management training."

The Clinical Director is fully responsible for performance and accountable for that performance; he is involved with day to day decision making, although on a part time basis, and therefore maybe the Clinical

Director is in danger of becoming peripheral to the decision making or delegates much of it.

Although the Clinical Director may have an own speciality passion, the issue is how to make room for understanding and to be concerned about other specialities, to learn to represent corporate directorate interests, and to put these aside when necessary for unit corporacy. Clinical Director for all the surgical specialities:

> "I am quite pleased with the progress we've made, we're not all the way there, but we became a trust last April and I became a Shadow Clinical Director almost two years ago and we've created a corporate being of a Surgical Directorate within a large trust which didn't exist before, so that's a bonus."

The Clinical Director cannot be all things to all people, but has to attempt to be informed of all directorate business, not necessarily being party to all decisions as this is not only unrealistic but intrusive upon others and obstructive to their proper functioning.

The Clinical Director also has to do a fair share of devolving authority and decision making. All staff need to have confidence in their director's common interest in all and the holistic approach to the directorate. This new, key player must be trusted to sacrifice self interest for corporate well being and development. Staff motivation and goodwill will be lost if they see any sign

of their director seeking personal or professional power rather than equity and accountability. Medical Director:

> "One of the current problems is getting the Clinical Directors to give up power to the Associate Clinical Directors."

And a Chief Executive:

> "A lot of Clinical Directors were unhappy when we devolved to cost centres and the ward sisters ran the wards."

And a medically qualified ex UGM;

> "We then had the devil's own job to persuade even Clinical Directors to de-centralize."

A further dilemma is coping with a UGM/CE who appears to lack the ability or confidence to devolve. In fact poor managers seem to have been supported by the medical staff. Neither the manager nor the medical staff may be even aware of this fact, such is the loose management structure that some hospitals have had. ex DGM:

> "It is possible to rehabilitate a UGM or Chief Executive. They have to be involved in and understand the organization though, but very few have even attended an operation. There are hospitals I know where the medical staff collude to keep a useless manager in post."

And another ex UGM:

> "A poor manager can be supported by the medical staff. Some hospitals are not really managed at all but have a very loose management arrangement although the doctors

> may not realize the fact. There is a need to understand the managers' career structure, where they come from, where they were before that, their referees and mentors. They will probably have a role model and then you understand."

And finally there is difficulty of dismantling old bureaucracy. I found a couple of examples of key figures in pre reform management structures apparently reluctant to devolve. This appeared to manifest itself primarily in leaving old structures in place while keeping information from the new. Medical Director:

> "I think it was Marx who said that parallel structures subvert the organization. If you leave the old bureaucracy in place and introduce the new structure alongside it, you have problems. When we started, we started afresh."

And a DGM supported this:

> "A bureaucracy is very difficult to dismantle, the bureaucrats within it resist. Districts and Regions resist, doing everything to hang onto power. However Trusts and Fundholders are changing that by pulling the power away."

16.10. Conclusions

Having in this chapter considered some of the characteristics and concepts of involving clinicians in management this concludes the data section. In the next chapter I will try to pull together some of the essential strands that have emerged out of the seven data chapters.

CHAPTER 17

PULLING IT TOGETHER

17.0. Introduction

Jaques (1978), defines a profession in this way:

> "At a certain stage of development the possibility of managerial control of professional members by non members must be excluded. This happens when the latter can no longer judge the competence of such professionals nor assess the technical problems encountered. Only monitoring and co-ordinating role relationships are possible in this context."

Much of the work of the NHS is carried out by professionals largely working on their own or in very small teams. Indeed the essence of professional work is that the individual has discretion to adjust the work to the situation and to have independence of action when required. But this independence may lead to a certain degree of isolation and it does not encourage a wider team approach within a profession. And this is one of the issues being addressed by the changes which are occurring in hospitals to create a more team orientated approach, as a medically qualified Chief Executive put it:

> "We are trying to engender a team approach, delegating responsibilities and giving for example, ward sisters control over everything that goes on, on their wards."

The consultants are being given the opportunity to participate in management, the decision making and the changes which are occurring. As a Clinical Director put it,

> "Clinicians rather than being alienated from decision making are being brought to the fore."

They are recognizing that they need certain skills for which they have not so far been trained. One Clinical Director's comments were typical:

> "We will need help, support and training to fulfil these roles, but many doctors are willing to do that if asked and the involvement is real."

Managers recognize the doctors' need for some new skills, as one, talking about the skills required by consultants in general and Clinical Directors in particular, mentioned the need for

> "The learning of management as well as other general professional skills."

And many managers support the view that they should be involved, a typical comment being:

> "Doctors with management flair and leadership skills should be encouraged to take their place in the management of the health service."

And some consultants do accept also, that they have a responsibility in this direction. One said:

"Clinicians are the people responsible for initiating the expenditure. It is therefore important for some clinicians to accept responsibility for management and to be prepared to play a leading role in managing the affairs of the hospital."

And they must have responsible reasons for that involvement;

"Furthermore doctors must be able to manage themselves and others and to assess and evaluate the proper use of available resources for the best, most effective and most efficient delivery of health care."

17.1. Some Dilemmas.

Several discussions brought up the dilemmas which consultants had thought might occur or which they faced already. This is a subject I shall return to in the last chapter on directions for further work. These dilemmas are: that doctors were highly motivated but have their own objectives; that doctors work very hard but had little time to devote to learning new skills. Also put as continuing to do what they did best but having to develop new skills; safeguarding the doctor patient relationship but caring for the organization; the dilemma of a restless search for excellence while being prudent with resources; a feeling of independence, isolation etc., yet now the need to cooperate with others; that doctors were highly motivated but have their own objectives. Many of these dilemmas have not been fully

resolved but since they have been recognized, it means consultants are no longer at the beginning of the process of change.

For the centre there is a major dilemma over the issue of clinical freedom. On the one hand Schon (1983) shows how control over clinical work enables the medical profession to control the distribution of health care resources and that successive governments that provided these resources became increasingly frustrated that their priorities, such as the care of the chronically sick, were frequently ignored. As a result from about the mid 1960's onwards governments began the first of a series of attempts to reform the NHS, which in retrospect can be seen as attempts to curtail the control that the profession had over health resource allocation. But Klein (1989:86) illustrates the positive political advantages that central policy makers can derive from the doctrine of clinical autonomy, when clinicians rather than Ministers or civil servants decide on priorities.

For the managers there is confusion over clinical freedom. Some feel that it exists and will continue to do so, and the following are typical comments by managers:

> "First of all it is essential that clinical freedom is there and exists and continues."

"Doctors are and should be the sole arbiter of what treatment is given to an individual patient."

"Only career grades like Consultants and General Practitioner partners have clinical freedom; trainees do not, but it is important and should continue."

On the other hand many managers do not agree and in addition, feel that clinical freedom is a myth that never really existed:

"I think you have only to look at some of the writings previously, does clinical freedom really exist? Did it ever exist? Doctors do not really, and have never functioned in a free way."

"I think what really has to change is the underlying premise that true clinical freedom really does or has ever existed."

"I would like to challenge the idea that clinical freedom has ever existed."

Other managers were more uncertain about the future of clinical freedom:

"Clinical freedom, it may get more and more difficult. Everyone will still say clinical freedom exists but the exercise of it has constraints already, who knows how it will go?"

Some were not even clear about what it really meant:

"I think clinical freedom is about social access. Social access is all about waiting lists, where doctors play the resource game. Social access is really public decisions about investment; that is not an issue of clinical freedom, although it is an issue that most doctors see as their preserve."

Even some doctors are not clear about clinical freedom Shields and Leinster (1993):

> "It is debatable whether true clinical freedom in fact ever existed."

17.2. Opportunities for Change.

Clearly doctors are the key users of the resources available, and they are potentially well equipped to understand and communicate with other doctors. But many of those appointed to managerial roles, Clinical Directors and Medical Directors, are relative amateurs as managers, although quick to learn and keen for more training in those well decentralized hospitals. The following are typical comments by Chief Executives of well decentralized hospitals:

> "Doctors with management flair can play an important role in the efficient running of hospitals."

> "I simply could not run the place the way we do without these guys' (referring to the consultants') help."

Many have been appointed to the role unwillingly in centralized hospitals. In one hospital in this study over a quarter of the Clinical Directors were appointed because no one else would do it. The most commonly cited reasons for this unwillingness were lack of time, lack of training, lack of recognition and lack of reward:

"The one thing we need is time to be Clinical Directors."

"I would like to be paid for being Clinical Director or be given time to do it, or both."

"We need at least a session of time to do it in and space such as an office to work in."

Some are wreckers hoping to fight the changes from within until they go away:

"If we keep our heads down and don't cooperate too much, nothing will change in the end. Nothing ever does, there have been dozens of reforms in the past and there will be dozens more. Let the management get on with constantly changing things. So long as we just keep seeing patients, that's the main thing."

Some are there for reasons other than managing resources, such as personal power, personal ambition and personal prestige, seizing the new opportunities presented by decentralization when it came to their hospital:

"Gives me more influence than many other committees."

"Gives me more influence over my colleagues."

Others were more constructive about the changes and the opportunities. One manager felt that

"The directorate structure offers a chance to effectively engage a range of staff in discussions about how to improve the delivery of care and make better use of scarce resources."

A Clinical Director felt that there had been

> "change from a reactive rather than proactive style of hospital management."

Another agreed:

> "An emphasis on development and change rather than care and maintenance. The former includes information analysis to assist strategic and business planning, external communication, relationships with purchasers or General Practitioners, culture change, (including quality, patients charter, medical audit),new developments, special projects and initiatives etc. These require a proactive focus often with a longer term framework."

And another manager comparing the old systems with the new opportunities said:

> "Organizational pressures which encourage fire fighting, fix it, reactive management responses rather than developing new initiatives or different ways of delivering services. Outpatients where piecemeal problem solving has been encouraged rather than a radical consideration of the changing external demands and the impact on the service now required."

17.3. Information Problems

West (1988:146) felt there were too many central initiatives which forced managers to spend large amounts of time on information collection. Information has assumed a much more central role in the operational management of a hospital. Unfortunately the computer revolution has made possible the production of vast quantities of information; the problem is that its very

abundance can sometimes obscure the essential and the relevant. Control of information can provide a means of controlling power. As one manger said,

> "Management can retain control by controlling the supply of information."

Another manager felt that,

> "In an era of rapid cultural change factual information is an essential aid to assist and force change to take place; without it arguments are conducted in a welter of supposition and personal opinion."

What seems to have happened however is that previously information gathered peripherally by mainly Medical Records departments was forwarded centrally through District and Region to the DoH. It was then collated and published and many consultants were surprised at the inaccuracy of the data.

With the new management arrangements the Clinical Directors have a vital need for correct information, and the data is gathered peripherally still but within the department, by the members of the department and not in a mindless paper exercise. The data is being presented from the bottom up rather than vice versa, and is proving much more accurate. A Chief Executive,

> "The Clinical Directors tell the Management Board the position on workloads and targets now rather than vice versa, where the Finance Officer used to present the hospital data, which none believed was ever accurate."

And a Clinical Director:

> "The quality of information coming from the actual directorates is much more accurate, and therefore useful now."

Another medically qualified UGM said:

> "Good information systems are actually one of my four criteria that you need to introduce it, but they're not the first one."

Interestingly information, information collection and information collection systems seemed very high on most people's agendas for importance regarding the changes that were occurring. Although computerized information technology seems far more sophisticated and advanced in the United States, the most successfully decentralized hospitals in this country felt that such technology was not the most vital factor in change. One medically qualified UGM from a hospital that has been decentralized for several years stressed this, referring to some hospitals which he had seen which were having problems:

> "They are going the wrong way about it, they are introducing information systems and then looking at their management structure whereas my argument has always been stuff the information systems, get your management structure right, then think about what information systems you require, because if you do it the other way around, you'll get the wrong information systems, or you might, or you're wasting your money, because nobody will properly use them."

The essential factor about information was that it relates directly to the costs within the directorate. In other words changing from functional budgeting to management budgeting. A Clinical Director:

> "The next thing actually has to do with information systems. The first thing you have to do to introduce such a system is introduce management budgeting, and that means your accounting system has to be changed so that you longer account the institution and functional groups, doctors, nurses and so forth, you've got to have a system for spinning those costs down to the clinical teams concerned and that's got to be done immediately. But it's not difficult to do. That's the key first information step you've got to take, then of course you've got to introduce all the other information systems, but most of those are actually directed to improving patient care, or they should be. With a decent PS system and outpatient appointment system, transmission of information into labs and x-ray departments and clinics, all part of running a hospital effectively, not about saving money, but you can tack on the saving money, costing systems to them."

Many hospitals seem to a been carried away with a tide of enthusiasm for information technology forgetting that the emphasis finally had to be on involvement of the professionals in management. A Chief Executive:

> "Resource management, instead of emphasizing information systems, emphasized in my view the involvement of professionals in the management and then the information system. So when I see somewhere that's not working it begs [i.e. raises] the question, are they doing it properly?"

17.4. Future Role of Central Management

Lastly it should not be forgotten that some of the dilemmas fall to the managers. Some Clinical Directors

have been given administrators to guide and brief them, or a Business Manager, and this might be a cause of resentment to those managers who feel that they could do the Clinical Director's job and are indeed doing much of it without the pay (some of the participants in my feedback sessions asked "what pay?) and responsibility to match. Some doctors do carry out their new management role for no reward and in addition to their existing workload.

The radical change in the way a hospital is managed is not just a change which is facing consultants. The more senior managers at UGM, DGM and Chief Executive level are affected in more ways than they think. Several Clinical Directors agreed with this when their attention was drawn to this, in line with this a comment from a leading academic:

> "With the change to clinical directorates the managers are in new ground too, they too are not used to management either, having been administrators."

The Institute of Health Service Managers are also aware that this might be a problem, (Charlwood 1992);

> "For managers the future is a lot less distinct than it used to be."

There are also problems after being Clinical Director. If there is a hierarchy of medical managers, what can the

non medical lay management do when they have reached a certain level if they cannot reach the top? For the administrators it remains an unknown, an unanswered question.

Decentralization of decision making and the use of the directorate structure may leave certain functions in the centre. Finance and Personnel and other central support departments are not usually completely devolved, and an arbitration function will need to be performed by the centre. A Chief Executive:

> "There remains an enabling rather than a constraining role being performed by the centre and central support departments."

17.5. Experience of Clinical Directorates

Many consultants recognized that a central plank of the Government's attempts to improve efficiency in the NHS over the past few years is an increased involvement of consultants in the management process. A medically qualified Health Care Academic:

> "Particularly it was hoped that clinicians would thereby have a greater role in all important decisions relating to clinical priorities and the use of resources, and this pre-dates even clinical directorates with clinical budgeting and resource management."

Initial experience with Clinical Directorates at hospitals like Guy's was encouraging, and although there has been no uniform pattern, changes in this direction are now in place in most hospitals in the UK. At the same time the introduction of the health reforms began to be introduced, and then the work of the clinical directorates took an extra dimension in many hospitals, concerning the content of contracts with purchasing authorities and a number of quality issues.

Initially consultants found that they were given insufficient administrative and secretarial help, but many directorates now have a Business Manager, a Nurse Manager and others with specific administrative skills within the management team. With budgets properly devolved to the directorates, rationalisations within and between clinical services becomes a possibility. Some felt that

> "only the unpleasant tasks have been fully handed over by the Chief Executive and hospital board and that there is an even tighter bureaucratic control from central management. Indeed in some hospitals consultants have become disenchanted with the process and have been replaced by non medical directors."

Part of the disenchantment relates to the rapidly increasing extent and complexity of the managerial work involved. But more important, is the lack of true devolvement to clinical directorates in some hospitals.

And I have already alluded to the desire of some managers to devolve responsibility without authority.

And as the health service reforms take effect there is no likelihood of managerial tasks for doctors lessening. The following statement was echoed by many Clinical Directors:

> "The 1-2 sessions that were given over to clinical directorate work seem to have extended to 3-4 sessions. Conflicts with clinical work are an inevitable result especially for those in teaching hospitals with the additional requirement of academic activity and research."

A number of Clinical Directors supported the contention that once the work of a Clinical Director extended beyond two sessions it was because of too much administration rather than management, and this probably indicated inadequate managerial support from the Business or Nurse Manager, or insufficient trust or delegation to them.

There was a lot of inequality in the way different hospitals recognized or rewarded Clinical Directors. And there appeared to be a strong correlation between what the hospital received from the system and what the hospital invested in the system. One Clinical Director spoke for many when he said:

> "Managers receive their performance bonuses and the doctors contribution in the clinical directorate must similarly be adequately recompensed. Some way of giving

recognition to the importance of such posts in the medical staff structure also needs to be found."

17.6. What Next and The Future

The way consultant work was established in the NHS leads to difficulties in setting up a more hierarchical system to encompass the wider role and greater responsibilities of the Clinical Director because all consultants are considered equal and independent. There was a recognition however that this might change over the next few years with the introduction of more subconsultant specialist appointments. One Clinical Director summarised it thus:

> "There is however the chance for this to be changed now with the almost certain introduction of a new specialist grade below that of consultant and over which there could be established the final top post of clinical director. For each of these categories of appointment there would need to be a separate salary scale along with allowance for seniority. The commitment in return from the doctor appointed to a clinical director post is, with respect to the acquisition of extra knowledge and skills in health service organization, in management, accountancy and Information Technology, so that he is as expert and informed in these new areas of work, as in clinical practice. Attendance at instructional and interactive courses is likely to be part of this and will need facilitating."

Clinical Directorates as a means of involving doctors in managerial roles in hospitals are a recent development in this country but what of their future and how important are they? Maxwell (1992)

> "felt absolutely no doubt about the importance of a strong bond between professional activity on the one

hand and the general management of the institution or agency on the other. The bond is necessary in all professions that work in a larger organisation for example engineering, for example, much of the law, and the church but peculiar characteristics in health care are, the need for several professions to work together, each exercising professional judgement in its own field. The tension between the needs of one patient and the needs of others; a tension that is not well recognised in the Hippocratic tradition. The difficulty and pain of some of the decisions that have to be made, in conjunction with patients and their families, about when to treat and when not to do so. And the tightness of resource constraints and the need for choices within the resources available, choices that clearly ought to be professionally informed, but equally are public policy choices for which the institution is publicly accountable."

He felt that clinical directorates (on the Johns Hopkins model) were a means of achieving such a bond, and that is why they are important. They are not an end in themselves but a means to an end. They are not guaranteed to work; most of all they depend on the competencies of the consultants, committed to leadership roles, and to a confidence in the arrangements from both the professional side and the general management side. When they work, the effect can transform the institution, but you cannot necessarily assume that the impact is permanent. Once they deteriorate, and confidence in them weakens on either side (professional or general management), they are hard to rebuild.

In the end they are the alternative to professionals working in the institution but not as part of it, as in a private hospital, or professionals directly managed by general management, doing what they are told.

CHAPTER 18

KEY STRATEGIES FOR CHANGE

18.0. Introduction

Because doctors regard money as not central to the work of the NHS in the same way as it is in most commercial companies, it has been difficult to get medical staff to face up to financial problems or indeed to admit that financial rather than service factors were necessary reasons for change.

What then have I discovered of the needs for involving doctors more in management, decision making and change in hospital? A number of key areas of discussion have repeatedly come to the fore with both doctors and managers. They include structures, processes and skills required.

18.1. Cultural Change

A change of culture is required to introduce a new management idea, and I have seen evidence of this change since the beginning of the project. Previously most management had been described as fire fighting; there were many superficial changes and random initiatives. Resource Management, Clinical Budgeting, Awareness

Training, Technical Needs Analysis, have all been referred to, and all are efforts to create a sense of progress but they have been only partly effective.

The culture of the hospital needed to be understood and dynamically managed so that the powerful and pervasive built-in inertias remain as they are and cannot gain strength thereby foiling potential change. The time and energies of doctors, nurses and managers have in the past been diverted into battles rather than establishing commonalities, which might make war between the various groups unnecessary.

In the past changes have been introduced which on the surface have produced change for managers to see, whereas below in the body of the organization there has been alienation and disaffection. Financial targets and activity have been achieved but with the result of low morale and minimal participation. The doctors have fought the system with a kind of guerilla campaign to maintain the status quo. Running the organization below peak efficiency has been wasteful and negligent. Shortell et al (1990) demonstrate that

> "When management adopted an interference strategy aimed at cost containment and quality assurance, confrontations ensued. Strategies which allowqed more clinical autonomy and let clinicians shape managerial behaviour were necessary to reduce conflict."

The need for a strategy for cultural change was urgent, but the organization needed to be understood, manoeuvred, adapted and prepared for the radical shift in management style. It was vital that UGM/CEO's addressed issues of cultural change and that doctors attempted to understand the changes about to unfold.

18.2. The Doctor's Responsibilities

The person in the post of Clinical Director has to have the support of the majority of medical staff as the organizational head, leader and figurehead of the directorate, responsible for the day to day operational and the strategic management of the directorate.

18.3. The Opportunities

With clinical staff supported and empowered to make operational decisions the hospital at corporate level can then be freed to think clearly about strategic issues, direction and monitoring. New challenges and opportunities are opened up for, and welcomed by, many. The full potential of the hospital staff can be realised. Cost awareness can be seen and used as creating opportunity rather than inhibiting activity. Clinicians may then discover enthusiasm for management and an inherent ability. The freedom and power this creates should replace the authoritarianism of the old managed

system. A re-evaluation of roles for both doctors and managers is necessary. Boundaries and traditional roles change; people may feel threatened but the change should produce benefits in greater democracy and awareness, with considerable benefit to the patient as difficulties are confronted and addressed rather than ignored.

Consultant involvement in management has been a controversial issue. As I have shown some take the view that doctors should only practice medicine, for which they have been highly trained, and not dabble in management for which they have until recently had no training. "I'm here to treat patients" is a familiar phrase. An alternative view is that involvement in management extends clinical freedom, and it may even be considered unethical not to be involved when resources are limited and finite, and that a strong clinical input and advice is vital, without which inappropriate decisions and actions may result.

18.4. Manager as Allies

Few developments take place in health care services which do not involve the relationship between clinicians and managers. The managerial clinical interface is crucial. Pettigrew et al (1992: 282) found:

> "a wide variation in the quality of such relations, and when clinicians had gone into opposition, they could

> exert a powerful block on change. Perhaps more surpringly managers also varied in the extent to which they saw relationship building and trading with clinicians as a core part of their brief."

The importance of effective managerial clinical relations in stimulating strategic change has also been reported in studies of the US health care system. Shortell, Morrison and Friedman (1990:237) present this as a dominant theme in their work:

> "emphasizing the significance of looking for common ground, involving selected physicians early on in planning, carefully identifying the needs and interests of key physicians, and working on a daily basis to build a climate of trust, honesty and effective communications."

Hocking (1991) identified a similar pattern in the university sector,

> "where relationships between professionals and administrators could be a stimulant or block to major change."

Pettigrew et al (1992: 283) feel that:

> "Manager clinician relations are easier where negative sterotypes had broken down, perhaps as a result of the emergence of mixed roles or perspectives. For managers, it was important to understand what clinicians valued (medical records may be not so important to managers, but are of great importance to clinicians), and hence what they had to do to engage in effective trading relations. Those managers who were best were those semi immersed in the world of clinicians."

I have given an example in Chapter 13 section 14 of a managers failure to understand the importance clinicians attach to medical records. Progress must depend on each

having a mutual understanding and recognition of each other's skills and knowledge. It is equally important that each group should be prepared to allow the other to bring that skill and knowledge into management. There are medicine for managers programmes seeking to promote a manager's understanding of the problems of clinical practice and how that effects managerial issues. Doctors are now being allowed more, even encouraged more, into managerial involvement and they too need to understand managerial practice. An integration of managerial and medical values is the sensible way forward, with the creation of goals and objectives common to both.

Fitzgerald and Sturt (1992) highlight how doctors' values can be a barrier to teamwork and collaboration:

> "Doctors often only socialise with other doctors. They may only be comfortable with their "peers" and often like to "talk shop" using impenetrable jargon. (This is also partly true of managers whose jargon is often a sore point with doctors.) Because of this social barrier, doctors often believe that managers hold completely alien values. Their descriptions of managers are sometimes a grotesque caricature. This "stereotyping" (which works both ways) is a barrier that can only be overcome by both sides taking a considerable risk in self-disclosure."

The extent of the mistrust and suspicion between doctors and managers is also demonstrated by the research of Stewart (1986). These relationships being identified as a major barrier to the involvement of doctors in the

management process immediately after the Griffiths (1983) reforms.

Enabling clinicians and managers to work together, discovering that former enemies are allies under the skin, can be disconcerting; finding mutual respect for each other's skills and knowledge can be both exciting and comforting.

18.5.0. Basis of Successful Clinical Directorates.

There must be a starting commitment from both the professional side (nursing as much as medicine) and the general management side to make the arrangement work. And this issue has been addressed in detail in Chapter 13.4.A. on managers being willing to relinquish managerial authority from the centre and 13.4.B. on Clinical Directors being willing to take on management responsibility. If either commitment weakens then it must be re-established or directorates will not do what they are there to do. (Maxwell 1992):

> "They are not guarantied to work - most of all they depend on competent people, committed to leadership roles, and to confidence in the arrangements from both the professional side and the general management side. When they work, the effect can transform the institution."

Following on from the issue of managers relinquishing control directorates, a Health Care Academic:

> "Clinical Directors must be given the necessary autonomy for expenditure and income, workload and quality within strategic parameters agreed by central general management. The clinical directorates must of course meet their targets. A director who fails to do so must be subject to proper discipline and ultimately to removal."

Clinical Directors must have authority to deal with problems within their directorate and general management must provide support. The remedy if a clinical director acts irresponsibly is to sack him or her from the post. Of course, this is not a sanction to use lightly and a wise and responsible clinical director will not in any case be likely to spring surprises on general management over important issues.

Information on performance and expenditure must be accurate and timely. That does not mean it has to be over elaborate and this has been discussed in detail in Chapter 17 Section 3. Maxwell (1992) feels that,

> "Calls for excessively elaborate systems are often a diversion and are dangerous because they are only too likely to bring disappointment and disillusion. But selective, prompt, "accurate enough" information really is necessary."

Clinical directors of necessity, to maintain the clinical perspective, have to be part time managers with a majority clinical commitment and serve for a limited period. As one academic put it,

"Otherwise they will in time lose the professional end of the support they need. They are there to lead, not to manage. Their roles need to be clear, as do those of the other leaders in the directorate, e.g. the nurse manager and business manager."

Careful consideration needs to be given to the number of clinical directorates to achieve the right balance between greater decentralization and effective control.

Health Care Academic:

"The necessary components of successful clinical directorates are that the number of directorates needs to be great enough to reflect the real variety of clinical activity (i.e. the equivalent of strategic business units), but they need to be grouped so that the directorates influence strategy and resource allocation for the whole institution."

There has to be effective and real decentralization, because the advantages are as one Clinical Director saw it,

"Decentralised decision making by those closest to patients should be faster and more responsive to ever changing customer needs. Those who know most about the health care business, i.e. the health professionals, should be the ideal people to plan the delivery of high quality services. More effective budgetary control should follow."

How it is done depends on agreement, the delegation of authority, the giving of responsibility and methods of ensuring accountability, the proper delegation of authority from Chief Executive and the involvement in the overall affairs of hospital. But responsibility and

authority must be "co terminus" as one participant put it.

To function, a Clinical Director must receive adequate support, and this falls essentially into three areas: information, advice and managerial.

18.5.1. Information

Information must be accurate and timely and can often be provided by the Nurse Manager and the Business Manager, although there may be a need for an external input from the Finance and Business and Contracting departments.

This information support is necessary as without it reliable and timely information decisions are difficult to reach. The Business Manager's role is crucial here, firstly as a collecting and sifting point for locally and centrally produced figures and statistics, and perhaps more important, to condense and simplify the information into a user friendly form.

The information required is in the area of budgets, identifying areas of under and over spending and presenting recommendations for any action which may be necessary to the Clinical Service Team (CST), as well as the monitoring of all the various contracts, activity

analysis, coding, case mix and DRG's, manpower and general business planning.

Most directorates use the service departments e.g. pathology, diagnostic imaging, operating theatres etc, and many hospitals are moving towards devolving the budgets for such services to the specific directorates on a cost/income basis and this may include the remedial therapy professions as well. In all instances the pattern of service provided and the cost implications do need to be agreed.

18.5.2. Advice

The Clinical Director needs advice in unfamiliar areas of expertise, not infrequently personnel and financial matters from the Business Manager, but in addition he may require support from outside the CST from Personnel (Human Resource) and Finance departments.

In the final analysis serious disciplinary matters within the directorate now fall to the Clinical Director for resolution. This is not a field in which many doctors have expertise. Several Clinical Directors had found themselves involved with disciplinary hearings and dismissals for which they admitted no experience or training. In such circumstances the advice of the Personnel (Human Resource) department is essential, and

those who had received such support and advice when necessary expressed gratitude for this.

18.5.3. Managerial

Managerial assistance in the day to day control of the staff in the directorate is again provided by the Nurse Manager and the Business Manager.

Managerial support is necessary because it is impossible for a Clinical Director to retain continuing clinical workload without being able to delegate some managerial responsibilities for nursing and clinical staff or in some directorates such as laboratory services, radiology and otolaryngology etc, for other professionals.

All managerial problems which may arise in any area should be discussed in the CST, consisting of the Clinical Director, the Business Manager and the Nurse Manager, whose meetings may often prove an invaluable support mechanism or give the opportunity for fresh and innovative suggestions and solutions.

In respect of senior medical colleagues much can be achieved just by mutual sharing of budgetary and performance information and peer review, without the need for any confrontational intervention.

Few doctors have financial training and if it becomes apparent that the budget for whatever reason is not going to balance and the matter cannot be resolved by the CST, advice from the Finance department on ways of addressing the situation can be a vital support factor especially if working relationships can be built up. It is also necessary at the creation of the clinical directorate to establish what your budget is and agree to it, and to establish the rules. A UGM:

> "Management retains power by not setting out the rules of the game."

It is also necessary to see the directorate budget in perspective. An Academic:

> "The Clinical Director needs to know the total budget position not just his own. The directorate budget is meaningless in isolation."

Medical Audit may become valuable as a management tool in ensuring that alterations, for example in treatment protocols, are properly costed and that full cost benefit calculations are carried out rather than new approaches being introduced on a tide of enthusiasm simply because they appear to be a good idea.

In this chapter I have outlined the areas and potential for successfully involving doctors in a management role

in hospitals. In the next chapter I will discuss in more detail the findings and conclusions of my study.

CHAPTER 19

CONCLUSIONS

19.0. Introduction

This chapter summarising the main work of the thesis is divided into two sections:

A. A review of my personal reflections during the three years of this study.

B. The conclusions that I have been able to draw, Decentralization with agreement on responsibility, accountability, authority, and the importance of agreeing ground rules. Issues around clinical freedom and a collection of ideas around the relationship between managers and professionals and the attitudes of doctors to management roles.

And at the end of the chapter I will set out a number of basic principles for the effective involvement of clinicians in management.

19.1. Personal Reflections

This section is an opportunity to reflect on all I have learned personally and how I have changed as a result of

undertaking and carrying out the work. From the outset I kept a diary of thoughts and ideas, not only my own but those of others that came up in conversations.

It is fair to say that this project has totally dominated not only my life for the last three years, but also that of my colleagues and my family. It has been researched alongside my career as a hospital consultant, part of which involved being Clinical Director for my department, in addition to having a number of Regional committee commitments. For reasons of finance not least being father to three teenage sons I have also continued with some private practice.

Despite my initial anxiety at the prospect of embarking on a non scientific based research project after so many years of hospital based clinical work I found I became quite addicted to the topic. I began with the preconceived notion held by most consultants that health service managers are of poor quality and that most doctors could do a better job of running hospitals. I thought that consultants were rather like entrepreneurs with imagination and flair whereas managers were second rate administrators, the typical stereotype image so beloved of the medical profession. I little realized how those views would change over the years, not once but many times. I began to think about the values of

consultants and managers, an issue clarified when I read Handy's "The Gods of Management" about a year later.

Changes in the health service seemed to be occurring every few years. This seemed to indicate that whatever problems there were did not have simple solutions, an issue referred to on p 3, although on considering the changes I realised that the changes were only in the management structure not in the actual service. At that early stage I could still not clearly resolve all the issues.

As I analyze the data and try to tease out the findings and draw some conclusions I am able to identify two main strands, personal learning and the substance of the thesis, although both are interlinked.

Some of my presumptions when I began this research have changed and some have been confirmed by the process. I thought in a simplistic way that I would find doctors would make better managers and that managers know nothing about the problems and dilemmas faced by doctors and medicine in general. This was not the case.

I had assumed that professionals could and should only be managed by professionals with the same background, which from my research experience I now realize is neither necessary nor of any advantage to the organization. In

some hospitals in the United States doctors did try running hospitals but according to the Nursing Director of a prestigious large hospital things changed because:

> "the physicians had not spent a lot of time educating themselves in the area of business and management; they considered because they had a degree in medicine they knew how to run a hospital. Well, they failed miserably, both in the area of finance and in managing people because in a big organization you need to know how to manage people."

I had also hoped to discover some simple explanation or underlying mental reasoning for this, but I found no simple explanations and whatever the unconscious mental processes they were inaccessible.

I did as expected find that doctors and managers have different values and attitudes and I confirmed that the doctors' view is one of thinking solely about the one patient and doing everything possible for that patient regardless of cost and I confirmed that the managers regard their priority as doing the most for the maximum number of patients within the resources available. I have concluded that there is a need for partnership and collaboration, see page 353. I also intend to discuss this further in a later section, although doctors' lack of interest in management (page 41) is working against hope of cooperation.

I now know much more than I did about how and why there is a suspicion of too much central control, that is relevant to the remarks above, and I have drawn the concept that in spite of apparent devolution, central control has tightened.

I found that managers tend to be driven by contracts and feel that the primary role of the hospital is to fulfil contracts. Therefore, managers may be regarded as having moved from being administrators to becoming entrepreneurs. I discovered that whereas doctors see the role of the hospital as solely for the purpose of treating patients, some doctors are recognizing that their environment is altering and they are accepting a role change from authoritarian to listening and now to participating. See pages 52, 60, 93, 99, 288, 295, 334 and 435.

There are clinicians who think managerially and strategically and successful Clinical Directors are increasingly part of such a group. I have already referred (page 463) to Pettigrew et al (1992: 284);

> "These are clinicians who think across the patch, and may even be able to speak for the medical community as a whole. Such strategic clinicians are critical people for management to identify, foster and encourage and under no circumstances should they be driven into opposition by trivia. Considerable managerial acumen was needed to foster positive alliances."

19.2. The Conclusions

The conclusions focus on three core issues. The most important is decentralization of management which has to do with the agreement of managers and professionals and includes devolvement of responsibility, accountability and authority. Next comes the question of the effects on clinical freedom and thirdly a collection of issues including the relationship between managers and professionals and their attitudes to the role of doctors in management.

19.3.0. Decentralization

The essence of decentralization is to increase the involvement of all staff in the operational management of the service. However, it is important that the responsibility and authority should be equally devolved and commensurate with the task, an issue discussed in Chapter 16 in general and section 7 in particular. I found a tendency for central management or administration to decentralize responsibility, but not to decentralize financial or operational authority. On the other hand the tendency is for clinicians in the decentralised management structure to wish to acquire authority without responsibility and accountability. These are issues which need to be frankly and openly discussed and worked

through for a decentralized system of clinical management to be effective within the hospital.

In general, greater efforts need to be put into the clinical and medical audit and education of staff, encouraging commitment to the hospital and devolved management to make it happen.

I am satisfied that decentralized units function more effectively than centralized units. In the words of Musch (1992),

> "Decentralized units are always smarter than top management."

19.3.1. The Four Vital Requirements for Decentralization

There are four vital requirements for successfully involving doctors in management:

1. Agreement
2. Responsibility
3. Accountability
4. Authority

Each has been defined and discussed in Chapter 16 Sections 16.3 to 6. As a Clinical Director put it,

> "When you involve the professionals in the management of any service, responsibility and authority have to be de-centralized in equal measure and accountability has to be clear."

They all need to be fully explored, in particular authority, which some managers and consultants seem to find the most difficult notion to grasp in the concept of management within hospitals, and needs to be clearly understood.

These basic principles must be fulfilled for effective involvement of clinicians in management. The Clinical Directors have to be part of the major decision making machinery and have real responsibility and authority and for all finances in particular (including contracting). There needs to be a single management body where decisions are made and it has to have the Clinical Directors on that body. I have discussed how there has to be a balance between a large numbers directorates but with a Management Board small enough to be practical, manageable and effective. As I have indicated each directorate needs to be as homogeneous as possible with comparable specialities, but not too numerous because of the resultant size of the Management Board. (see Chapter 18, p 467). Ideally the Clinical Directors should have a majority over the Executive Directors, who would normally be about five in number including, the Chief Executive, Nursing or Patient Services, Finance, Personnel or Estates or Business and Contracting. There should be no other managers sitting on the Board. This

decentralization is vital, and it has to include, finance, information and contracting.

19.3.2. Ground Rules are Important

It is important not to set up a new organizational structure without considering who makes the decisions, and about what. Frequently too much attention is given to structures and very little, or none to the rules by which it will work. It is also important to understand the new organization being put into place, and establish the rules by which it is to work, then if faced with the need to change, it is possible to understand how to cope with difficulties. The means of approaching problems should be clear even if the solution is not. It is also important to define the roles, responsibilities and relationships of Medical Directors and Clinical Directors, to whom they are responsible and for what. There are problems in encouraging consultants to achieve targets set by the Clinical Director. Doctors are a highly motivated group but they have their own objectives. It is important that mechanisms for maintaining relationships between directorates and of the consultant body within the hospital are supported by maintaining such bodies as the Medical Staff Committee.

19.4.0. Clinical Freedom

I have shown how historically hospitals up until fairly recently were cottage industries and the craftsmen or the technicians were the doctors who ran their workshops within them maintaining complete and total authority over their areas. According to the CEO of an American University Hospital,

> "The hospital administrator was relegated to a fairly maternal role of clucking around seeing that all these artists were happy and the best administrators were those that were able to keep their craftsmen the happiest. That paradigm is in full change."

Next, with more specialization and the appearance of technicians new people were fitted into existing departments or new departments were created. They all provided a service to patients but no thought was given to their function in a unit. The idea of a health care team is still beyond the comprehension of many people in hospitals. I have discussed on pages 60, 93, 99, 288 and 295 how doctors have moved from professional independence to interdependence, although many do not recognize this. And I have discussed (p.94) the resulting stresses in the system and (p.100) how the role of the doctor in hospital is changing and the way in which the medical hierarchy and power has changed (p.105). In addition to the effects of change from personal to agency medicine on (p.109-111) as well as the importance of personalized medicine to

clinical freedom (p.146-50) and the implications that flow from that. The conclusions around clinical freedom I have divided into eight separate sections.

19.4.1. Doctors' Perspective

I have referred to the idea that at the inception of the NHS there was agreement concerning clinical freedom. According to Klein (1989:82):

> "Implicit in the structure of the NHS was a bargain between the State and the medical profession. While central government controlled the budget, doctors controlled what happened within that budget. Financial power was concentrated at the centre; clinical power was concentrated at the periphery."

The bargain was to some degree frustrating for the doctors as the price of preserving clinical freedom was accepting the constraints of working within fixed budgetary limits.

I have found that unfortunately this individually they could or would not do. Tribalism and rivalry between specialities and departments prevented that. Secondly doctors fear that general managers are encroaching on their professional independence, their freedom to determine their working patterns and their clinical freedom.

Thirdly some doctors feel that clinical freedom is under threat by the government determined to make doctors more accountable for their work (Templeton, 1986) discussed on page 256. This phenomenon of control is appearing in every Western country (Loveridge and Starkey, 1992).

19.4.2. Managers' Perspective

For managers the bargain referred to earlier was equally frustrating. Enthoven (1985:9):

> "The consultants have accepted long term contracts with the NHS and limits on total expenditure in exchange for job security and 'clinical freedom'. Thus NHS management has very little leverage to make their services responsive to patient needs. To change the speciality mix of its medical staff, a Region must wait for deaths and retirements."

Managers feel that clinicians constrain managerial choices in at least three ways: firstly when they extend the range and cost of their activities without taking account of the resource implications; secondly they feel that a shift in clinical direction may owe more to personal interest than to the needs of the hospital; thirdly they feel frustration that these actions by clinicians can unbalance programmes designed for a district as a whole.

Managers therefore face the difficult task of persuading doctors to accept that their clinical freedom must be

counterbalanced by an awareness of and responsibility for, the effective management of resources. On page 132 I have shown how change is occurring with budgetary limitations.

Real power may now lie in the hands of purchasers (district and health commission managers and GP Fundholders), rather the providers (unit managers, chief executives and consultants), who can decide what to purchase. They will almost certainly take the view of the greatest good for the greatest number, rather than the clinicians' traditional view of the best for the individual.

On the other hand there may be power in the hands of the provider who having met the obligation to provide core services can decide what other services to offer, services as Hoffenberg (1991:14) says

> "which in a market environment will be taken on economic grounds."

But again this power has left the individual consultant in a position where he anticipates it may no longer be possible for a surgeon to use his clinical freedom to introduce a new operation, nor a physician a new diagnostic investigation or drug therapy.

Finally on pages 130 and 135 I refer to the idea that faced with a seemingly impossible managerial problem the situation may be resolved if developments result in all health care professionals having clinical freedom.

19.4.3. Government Perspective

The government believes a balance has to be struck between organization and clinical freedom. The government has already successfully imposed the principle of a limited list and in doing so has provided further evidence of a willingness to take on corporate interest groups which could extend to the medical profession.

It has challenged the idea that clinical freedom bestows an automatic right to use public resources without scrutiny or limits. Decisions by consultants to keep patients in hospital longer than necessary has implications for the NHS as a whole (Higgins, 1988);

> "All such decisions although they had crucial implications for the use of NHS resources, belonged to the sacred realm of clinical autonomy. Similarly the use of ineffective, inefficient or expensive methods of clinical intervention."

19.4.4. United States

American doctors have found themselves increasingly working to guidelines laid down by corporate bodies and

government. It has been argued that the medical profession in the United States is being de-professionalised as doctors lose clinical autonomy and simply become agents or employees of corporate providers of health care, the commercialisation of medicine producing its own decline. As Winkenwerder and Ball (1988) have written,

> "Increasingly, health care is perceived as a commodity that is produced, marketed, bought, sold and distributed".

Doctors in America now feel they are more controlled, and in more ways, than doctors in Britain. There are controls on who they can admit to hospital and how long those patients may be kept in hospital. There are many protocols they have to follow from when the patient is in hospital, to their follow up practices. According to one CEO,

> "There appears to be no doubt that doctors are enjoying far less freedom and are far more controlled in their daily operations although it requires someone with a little bit of perception to see where those controls are, and what it really means."

An American Hospital President said:

> "It is inarguable that physicians' autonomy has been significantly reduced in the last fifteen years as a result of external insurance and governmental regulations and controls of various sorts."

And another CEO said:

> "In the past it was unmitigated, unlimited autonomy which made medicine a marvellous profession for Americans; they now feel they're controlled."

19.4.5. Lessons from United States

Similar forces are at work in Britain in the NHS. Many doctors feel that the most recent proposals for reforming the health service contained in the White Paper (1989) offer the severest challenge to clinical freedom, in that it is proposed to remove many medical decisions from doctors and give them to managers who will act according to market forces, although power will not be devolved solely to managers but to managers and consumers, the latter through their general practitioners.

Now that the NHS is being marketed, fears have been expressed that the introduction of internal marketing with limited budgets for Fund Holding GPs and Health Authorities may lead some patients to question the motives associated with medical and clinical decisions, especially if they should be denied expensive investigations or treatment. (Drummond, 1990) comments:

> "fundholding may harm the doctor-patient relationship if patients become sensitized to the potential conflicts doctors face in weighing up options for care when some of the options demand expenditure from the fund."

However as Hoffenberg (1991:7) observed,

> "We have an obligation to use public resources prudently.....the intrusion of cost-consciousness into clinical judgements cannot be ignored. No society is capable of providing the best available care to all of its people all of the time. Cost-containment is inescapable".

19.4.6. Consequences

Despite the American Medical Association's rejection of socialised medicine because of its supposed threat to clinical freedom I found the British doctor by and large maintains more freedom of action than his American counterpart. Hoffenberg (1987) speculated that British doctors possessed far greater clinical freedom than their counterparts in America where three main forces had combined to curtail their clinical freedom. Firstly the advances in medical technology had resulted in amongst other things, patients resenting the authority of doctors and demanding a greater say about themselves; i.e. patient power. Pellegrino (1990) describes the

> "irreversible shift in the locus of decision-making from physician to patient".

Eddy (1990) adds that as a result

> "physicians are slowly being stripped of their decision-making power".

Secondly the dominance of the law and litigation forces doctors to surrender much of their freedom of action and adopt defensive medicine. Thirdly the costs of health care are such that payers, whether they be government, insurers, industry or individuals determined to regulate costs by regulating the doctors who initiate the expense.

The same process that now threatens the profession in Britain has already had considerable influence on health care provision in the United States and clinical freedom has suffered a similar decline over the past two decades. There, it has been the funding bodies, whether government, insurance companies or employers, who have attempted to contain runaway costs by placing more and more restrictions on clinical freedom. Such practice and demands suggest that there might no longer be grounds for justifying unmanaged status other than the provision of personal clinical services. Perhaps the move towards agency medicine makes doctors easier to manage.

19.4.7. Changes Are Occurring

There are consultants who are amenable to practising to suit the organization where no clinical priority can be established, and accepting that the hospital has to earn its money from somewhere. This is discussed on pages 52, 60, 93, 99, 288 and 295. One Clinical Director said:

"Most of us are supported by the institution and we want it to work, we don't want it to go down and therefore we recognize we have to get money and if the way of doing it is to be helpful and it doesn't make a big difference clinically.... I have been asked if I will do seven more knees very quickly, because if we do forty of a particular type of knee that I do, by April 1st then we get quite a large discount from the company that provides the knees; if I've only done thirty eight, we don't, therefore, it is please could I do knees, rather than hips. It doesn't make any difference to me, so I don't mind. If it's an advantage to the institution, one does the knees."

And patients are now being referred to as consumers, customers and clients. Relman (1987) wrote:

"The present trend towards market competition is clearly weakening the traditional values of our profession".

19.4.8. Clinical Freedom and Resource Constraints.

One of the issues that surfaced in a number of interviews was the question of the effect or possible effect that limited resources would have on clinical freedom. The consultant does have the discretion to make decisions about patients currently under treatment without those decisions being reviewed or overturned by anyone else, even someone from the same discipline. What has happened can be shared in a peer review context, where it can be discussed, but it is voluntary; no one can insist on knowing why something was done or overturn or change what is being done. That is the basic core of the discretion of the consultant. I have already discussed the limits

to that discretion and as one Director of Public Health put it,

> "the most obvious limit of that discretion is a contract to do certain things, within the law, the rules of General Medical Council etc., but the one that really matters of course is resources. You can only put someone in a Coronary Care Unit if you have a Coronary Care Unit with an empty bed, if you have not you cannot exercise your clinical discretion. Resources have increasingly been the major constraint. Now we are formalising, the resources that are available, they are being determined by some external body which is also specifying for the first time that they will only give money for you to do certain things, to certain people from certain places. That is brand new, it still fits my model of clinical autonomy, you can't do something unless you have the resources, but it brings in a whole new range of constraints on what you can do, from an external force, over which you have no power. These are people you cannot negotiate with."

Clinical freedom has to do with the relationship between doctor and patient, it does not directly affect managers. It is concerned with current patients being treated; you do not have clinical freedom to make decisions about future patients that you might have under your care. It is the issue of resources through contracts which seems to be the major threat to clinical freedom. A Director of Public Health again:

> "A major curtailment of the old clinical freedom to provide services you thought you wanted to provide is now by money, because you can only provide services for which you are funded. A major curtailment of the individual's clinical freedom is through contracts, I don't think most of our colleagues have realised that yet".

One manager supported that view:

> "I think there aren't enough resources for everything. And you can't actually take away the notion of clinical freedom and the judgement that implies, from resources".

Yet there are some doctors who believe this is not a bad thing. Consultant:

> "I believe the medical profession should lose some of its power, because actually the old medical ethic of saving lives at all costs, healing the sick whatever the costs, finding the cause of the illness whatever the cost, is an ethic which is no longer appropriate."

While a more popular view amongst those consultant clinical directors most convinced about the need for change can be summarised by the view of Clinical Director:

> "What a clinician wanted was clinical freedom and that required resources because if you didn't have the resources, you didn't have the clinical freedom. The question was, would we be able to direct more resource into clinical work as doctors than if we weren't involved? If we could increase the efficiency of our work we would maximise our clinical freedom. .....By being involved, you can make sure that the money that is available is used in ways which make the most medical sense to improve clinical freedom."

As a Clinical Director observed,

> "Things change the moment you apply cash limits, the responsibility of doctors within the organization changes. Because in a cash limited health service, striving for equity, everybody has to be accountable for what they do. Doctors have to be involved in making those choices".

Doctors are now becoming aware of finite resources, and some of them are prepared to make changes and no longer regard this as an infringement of clinical freedom. I also feel that to make doctors most cost conscious you need to devolve budgets as low as possible, even to individuals if necessary, so that they are totally aware of how they are committing resources.

19.5.0. Doctors Involvement in Management

I discovered why some of the things that managers do, or do not do, result in many of the problems in the doctors' rejection of management. These include: making promises that are not delivered; showing naivety rather than seeking advice; apparently being dishonest with doctors about financial limits; some departments spending to crisis point always resulting in money being found, which devalues the idea of sticking to a budget; a feeling that money will always be found from somewhere, District, Region or Government, as it would be politically unacceptable for a hospital to go broke. This is a large barrier to cooperation.

19.5.1 Doctors Neglect of Management

Many doctors admitted that the profession had neglected to become involved in management for reasons of lack of

interest, lack of time, and poor image associated with such involvement. In the States similarly as a Clinical Director told me,

> "Doctors have been very bad managers and what has happened in this country in the past few years is a direct result of our profession neglecting its responsibilities as far as management is concerned. We have as a profession neglected responsibility for containing costs and neglected responsibility in advising on the allocation of priorities as opposed to our own particular interest."

A Professor of Surgery put it to me:

> "There are several things that have happened in this country in the past fifteen or twenty years. The doctors have been very bad managers. Our profession neglected their responsibilities as far as management is concerned, our profession neglected its responsibilities in cost containment, neglected its responsibilities in allocation of priorities for the hospital, as opposed to an individual's interest.... that has been the mistake that we have made as a profession. As a result, as we are getting the crunch, the "Fed's" are cutting back, the State are cutting back, the County is cutting back and all the support that the medical profession used to get, especially teaching institutions, we all are now looking at what's what, and we may be a little bit too late."

Health management academic:

> "..as far as hospital consultants are concerned, there is an enormous need for medical leadership, the opportunity has been lost so far. The challenge of hospital care over the next ten to fifteen years seems to be absolutely enormous. The degree of change we can expect will be greater in the next ten years than it has been in the last ninety; unless doctors are leading that change, innovating, being creative, which they are as a group, and allowed to be so, and taking that on board, the health service is in deep water. Doctors can no longer be protectionist in the way they

do things, they must lead change, innovate, create a whole range of things which are important."

The way doctors choose to react to change in the fields of clinical management and resource management will substantially influence the type of career available to consultants in the 1990's. Perhaps at no time since the beginning of the National Health Service when the medical profession first joined in, have the choices and decisions been so important. If consultants become involved in resource management and medical audit both their management role and their clinical leadership will be enhanced. I have shown how doctors did not grasp the opportunity created by the reforms (p.42) and their involvement in management will strengthen rather than weaken their position (p.77).

19.5.2. Doctors' Support for Management

I found that consultants are divided between those who are now active in supporting the new management initiatives and keen to play a full participatory role in management, and those who are not. I have explained how I think there are probably different levels of commitment and I have discussed this in some detail in Chapter 14 Section 14.1.

19.5.3. Managers' Support for Doctors' Role in Management

I found that managers have divided opinions about doctors and divided views about the need to involve them in management. There is stress in the system between managers and professionals (p.94). I found that some are genuinely envious of doctors' apparent freedom and jealous of their education, dismissive of the genuineness of their values, angry at their arrogance and frightened of their own position if the doctors' role in management turns out to be a "sleeping tiger". Equally, many managers have genuine feelings of admiration, and a willingness to support and help doctors in their work.

19.6. Incentives and Disincentives

Like West (1988:56) already referred to in previous chapters (see pages 275, 303, 349, 385, 449) I found that incentives need to be introduced into hospitals, so that those responsible for inefficiency bear the costs of their actions. There are few or no sanctions or penalties for lack of interest in bed and theatre usage (Chapter 3 Sections 5.1.to 3.) Technical efficiency, the elimination of whims and personal agendas need to be addressed by clinical budgeting. He concludes:

> "To return to the airline analogy, it is clear that laymen cannot and should not fly airliners. But the financial and planning staff of the airlines can

legitimately lay down the routes and schedules for pilots to follow."

Fitzgerald et al (1992) also highlight that evidence suggests that clinicians need incentives to perform management roles, as well as support. There is evidence from other professions that underlines the problems facing professionals moving into a second career or adding to their specialism an additional set of knowledge (Perucci, 1973; Scheneller and Weiner, 1985; Earl and Skyrrme, undated).

19.7. Suggestions and Recommendations

There is a key role for professional staff and the professionals must become more involved in general management. Clinical Director:

> "The large number of separate decision makers in the professions is what separates health care from most industrial and service industries."

The old attitude (see p.46 on role models), to doctors' involvement in management was summed up by Musch (1992):

> "Doctors in hospital management are like eunuchs in a harem. They know how it is done. They have seen it done. But they cannot do it."

I hope I have shown that this attitude is changing. The management in hospital appears to be broadly divided into two parts, the guidance or strategy management, and

the delivery or operational management. The task of a Clinical Director is mainly concerned with operational management but, although not a representative of a speciality, is representing the clinicians as a group and should have a voice in strategy. In successfully decentralized hospitals, the Management Board is chaired by the Medical Director and attended by all Clinical and Executive Directors.

The Clinical Director must be participating in hospital strategy and policy formulation, and contributing to effective decision making within the hospital for which he should recognise corporate responsibility.

He should be responsible for innovating change and for responsiveness to change. Change is never easy. People resist it for many reasons, insecurity, social and economic loss. Kaluzny and Hernandez (1988) identify three types of change as a function of whether ends or means or both are involved. The process of change can be regarded as a number of separate processes, (Grant and Gale, 1990). First there is the recognition of the need for change, then the problem needs to be identified, together with alternative methods and strategies for its management. The selected method and strategy then needs to be chosen and the change implemented. And finally an evaluation of the success or otherwise of the change needs to be made. Though rarely, as the authors admit is

this a simple step by step process. All this is important as the Clinical Director has a responsibility to make the best use of resources. It can also prove whether the change was wise or whether further change is necessary.

Fitzgerald et al (1992), again referred to in earlier chapters (pages 398 and 464), highlight the emergence of the clinical manager as a new role.

> "It is not a part-time manager performing tasks as any other manager might do, Uniquely, a clinician manager combines direct and current clinical expertise with management expertise to take decisions about the range and quality of services offered."

The design of this new clinicians role should reflect these considerations, the need to perform certain core tasks, such as the development of the strategy for the faculty or speciality, and with others for the hospital as a whole, financial decision making, resource allocation and staffing strategies.

19.8. Characteristics of Managerial Success

There are certain characteristics which seem to distinguish the more successful doctors in management. Management research has increasingly focused on observing what managers do rather than on what they should do. Boyatzis (1982), to whom I referred in Chapter 16, see page 417, tried to identify the characteristics of

excellent performance. He concluded that a job is performed most effectively when three elements are congruent: the job demands, the organisational environment and the competence of the job holder. Competence for the task involves personality, values, motives, attitudes and behaviour, as well as skills and knowledge.

Firstly there are technical skills associated with the particular profession or speciality. These are basic skills and knowledge possessed to achieve success in a professional role. Secondly there are basic managerial skills appropriate to any managerial situation, for example leadership, people management, social skills, supervision and working with others. And thirdly there are special skills which distinguish the excellent manager. Some of these are personality features which cannot easily be learned. Others are more amenable to change or can be taught and learned. Making these distinguishing skills explicit can be an agent for change.

Two Clinical Directors:

> "Improving the service may mean doing things better, either faster with fewer resources to a higher level of quality, or achieving improvements in both effectiveness of the service and in the efficient use of available resources."

"Looking for and recognizing inefficiencies in current practice and generally looking for ways of improving how things are done."

Making things happen involves setting goals and achieving them. This is setting the direction of the directorate, providing a focus for the work of other members of the directorate. It may involve setting standards, delegating tasks to get work done or organizing resources to achieve desired objectives. Clinical Director:

"My job is to identify what the hospital requires of the directorate, and that depends on what the purchasers require. Then translate that into action through all the members of the directorate. Setting the targets and standards, organizing the resources to get the work done and monitoring the outcomes."

The Clinical Director needs to be able to think conceptually, analytically and strategically, if necessary breaking issues into component parts and re-connecting them into a coherent whole, in other words to think about the totality of the problem. He needs to be able to identify the key factors in a complex situation, and to question the basic premises and assumptions. Analytical thinking seems to feature highly amongst doctors because of their training, but it is necessary to also conceptualize and to relate issues to a broader picture and then make connections between different parts, to develop and use clear criteria for evaluating options, and to anticipate problems and develop contingency plans. Clinical Director:

"Can you visualize a long term picture of the future of the speciality and the directorate based on an analysis of its role and the likely future environment in which it will be trying to work, and from that develop some sort of strategy?"

In other words a Clinical Director must have an ability to learn and change behaviour as a result of experience.

The effective Clinical Director needs to be able to influence and persuade, trade and negotiate, plan and intervene. One method of influencing may of course be inadequate; it might be necessary to identify the key people who need convincing and to tailor an influencing strategy to the concerns of those key individuals or groups.

Clinical Directors may need to use networks to gain support, or personal relationships to bypass bureaucracy. This may be seen by the lobbying of influential people in advance of formal meetings, a method adopted by a number of participants in this study. It is also beneficial to keep key people informed on issues.

It may be necessary to elaborate logical arguments to influence people, to present or organise data to influence others, to make use of cost benefit arguments to influence those who make decisions about investing resource in developments, and it is always useful to be

able to appeal to the greater good of the hospital or community.

Turrill et al (1991) in a study of the excellent doctors in management referred to these types of characteristics as competencies and found that

> "These occur with sufficient frequency to suggest that they are too important to the role to be ignored. They may be termed the threshold variables in that they suggest the minimum conditions for fully acceptable performance."

They classified them as follows:

Achieving

Demonstrating enterprise and initiative

Thinking

Thinking analytically

Influencing

Influencing strategically and persuading rationally.

They felt that technical and managerial competencies are eminently trainable. These primary behaviours and the distinguishing competencies may be improved although only within certain limits of the individual's potential. They feel this results from the underlying characteristics of the personality and are the building

blocks for managerial process competencies such as team leadership, negotiation etc.

Some doctors they felt display a somewhat restricted range of managerial skills. Some outstanding doctors have a very clear view of their own role and the part they have to play within the overall process. Their common view, typified by Clinical Director,

> "is that management is about trying to do more with less, pursuing excellence with limited resources".

Turrill et al (1991:18) feel that

> "for many reasons not least of which is the time they have available, it may be that they are better placed to do this if they act as transforming leaders rather than transactional managers. Their choice of role will have a significant effect upon the process competencies required by them and their immediate team."

The operation of a successful directorate often rests heavily upon a team approach and the nurse manager and business manager play a significant part. The capability of each member of this group of staff is critical. Typical Clinical Directors' comments:

> "A senior clinician who is a "follower" or worse still an "opposer" who wishes to take the role to wreck the changes that he sees occurring around him is a recipe for disaster."

> "The most junior consultant was made Clinical Director so that the others could ignore him."

"Unfortunately most of the people involved in management and wanting to be involved in management have been people who have wanted to build their own empires, and they have discovered they can be very supportive of their own projects."

"In our own department the most junior of the three of us was appointed because they wanted an age range, they didn't want them all to be the senior, but they appointed the most junior for the wrong reasons. It created a big problem because my senior colleague wouldn't accept it and I felt it wasn't the right one either and in fact he was asked to resign after three months. Which doesn't go down well in any department, and it created a lot of unhappiness."

Similarly a senior nurse or technician who may have been successful in different situations will not necessarily have the correct distinguishing competencies for this new role. Perhaps the key position for the lead clinician is primarily leadership, in which case, it appears important that the Business Manager and Nurse Manager should develop the appropriate managerial process skills to support the leader.

19.9. Summary

Based on this study I consider that there are a number of basic principles for the successful and effective involvement of doctors in management in acute hospitals. As discussed in this chapter they revolve around a small number of issues such as decentralization, an understanding and agreement on explicit rules and clarity of roles. For convenience these can be listed

A. The roles and the relationships between the Trust Board and the Management Board of a hospital have to be explicit and clearly understood and agreed and the role of the Medical Director in relationship to his position on those two bodies also clearly understood and agreed.

B. There has to be a single Management Body or Board on which all the Clinical Directors sit. If only certain Clinical Directors sit on this Board there can be alienation within the directorates not accorded this role. This Board has to be where all the key decisions including financial and budgetary ones are made. The Clinical Directors should outnumber the Executive Directors. There should be no other managerial members on the Board, no other managerial decision making body and the CE or CEO must not in any circumstances circumvent this machinery.

C. The role of the Medical Director needs to be discussed openly and agreed so that everyone within the organization is clear, not only about the role, but also about the relationship of the Medical Director to the Clinical Directors and the consultants in general. The Medical Director has to be the link between the Clinical Directors and the Trust Board, although he does not necessarily need to chair the Management Board.

D. Similarly the roles and relationships of the Clinical Directors need to be discussed, agreed and formalised so that there are no confusions. They have to be part of the major decision making machinery of the hospital, and the link with the other members of the directorate.

E. The processes by which the organization will work have to be clearly discussed, thought through and agreed in advance so that everyone knows the rules by which they are working. Too much attention is often given to the managerial structures of the hospital with little thought being given to how it will work in practical terms. This is detailed in Chapter 14 section 2, see pages 363 - 374.

F. Authority and responsibility have to be equally devolved to Clinical Directors. Central management often tries to hang on by a variety of means such as holding on to information, finances, the contracting processes, too many central managerial functions or just by withholding support. See Chapter 16 sections 3 - 7, pages 420 - 434.

G. The importance of cross communication should not be forgotten to maintain relationships for example between directorates. The Medical Staff Committee which is not an executive or managerial committee should be encouraged.

In the next and final chapter I shall outline some visions of the future, the importance of bridging the

divide between managers and professionals and indicating directions where future work might be helpful in progressing the issues raised.

CHAPTER 20

SOME SUGGESTIONS AND DIRECTIONS FOR FURTHER WORK

20.0. A Vision of the Future

Hospitals staffed with highly trained, specialised personnel who cannot contribute their full potential means there is a gap between what is and what could be given, this represents a loss to hospitals and patients. For the individual professional the cost is frustration with the system and greatly unfulfilled professional expectations. Coordination over the majority of activities becomes difficult, and traditional ways of working may no longer be appropriate.

Increased resources, money, equipment, personnel are not the answer. More effective use needs to be made of existing resources through improved organization. Neither does restructuring hospitals by departments lend itself to resolution of these or any other patient management or administrative problems which cross two or more departments. Paediatrics and Geriatrics are examples of two Clinical Care Units or Groups based on patient need rather than anatomy. New trends developing are Cancer, Diabetics, Gastroenterology. There will be an increase of this trend towards patient need groups rather than specialities as we now know them. The split

between medicine and geriatrics has had its day; there will be a need to amalgamate directorates and different groupings will start to emerge.

We are entering a two dimensional matrix era with traditional services such as Finance, Human Resources, Hospital Services, Corporate Issues etc., on one plane and the Clinical Directorates on the other. But already some hospitals are entering the era of the three dimensional matrix, with Clinical Care Units in the third plane. These are units based on patient care groups such as paediatrics, cancer, diabetes, rather than anatomical areas such as dermatology, ophthalmology and gynaecology.

If the organization of a hospital is based upon the department and it is the Health Care Team that is required, the hospital needs a matrix structure, an organizational form which places high demands upon interpersonal skills. But the balance has moved towards requiring organizational change in health care institutions. By cutting across departmental lines and achieving coordination it is possible to create a unified matrix organisation. This may not be easy to implement or manage, as a matrix organisation requires management and interpersonal skills that may be lacking, but has many benefits in improved staff communications.

Charns (1976) showed how integration and coordination were central themes in business management but nonexistent in health care. The traditional theory was that in a hospital the organization must be based on departments.

Several problems facing an organization trying to integrate were brought out: communication was too often ineffective, as it is as important for information to go laterally as well as up and down; also the potential for misunderstanding was great, but was lessened in a face to face discussion; it was also important to identify leadership and educate the leaders.

The problem seemed to be mainly who are the potential integrators in the matrix. Doctors say they are more concerned about interpersonal relationships in their department, but also expressed a view that their main need was for more training in managing people. Managers might be expected to show creativity, but tend to work within formal rules. The high status and prestige of doctors suggest they might be likely integrators, but their extreme orientations to the hospital may make them inappropriate. Managers tend to have a closer relationship to the hospital than doctors but lack medical training and have lower status. In fact no group has all the requirements to be an effective integrator. The most logical choice, because he has the respect and

confidence of other members and a balanced orientation is the Clinical Director. Unfortunately, at present most consultants have limited management, interpersonal and group process skills. But things are changing. Enthoven (1985:47):

> "A promising trend is for some doctors to attend postgraduate courses in management and plan careers combining medical practice and management."

It has been said that "The modern hospital was designed in 1920 and has not changed a great deal since" (Drucker 1992). But change is occurring now, Clinical Directorates are operating as autonomous business units with decisions made as close to the patient as practical, and the directorate managing all its resources either directly or via an explicit contract between business and service directorates.

20.1. Bridging the Divide.

Stewart (1989) and Maxwell (1992a) and (1992b) and (1992c) talk of bridges and bridging this divide, as no one really wants a divide. (NHSTA 1989:7):

> "a measure of disagreement and conflict between managers and doctors over key issues can actually be

good for the Service, in that it subjects such issues to scrutiny from more than one perspective."

It is the suspicion and misunderstanding of others' motives that need to be overcome. Managers need to convince doctors that they too are committed to patient care although it may take a different form, and doctors need to show an understanding of the necessity for management and what it can offer. This is best done by personal contact, keeping each other informed particularly about likely changes, by encouraging doctors to take on managerial roles, by providing management training for doctors, by using appropriate change management methods to effect change, by learning what matters to doctors, enlisting their support and showing others that you, whether doctor or manager, are trustworthy.

Consultants are a loose knit peer group, highly individual, fiercely independent, hard working, taking enormous pride in excellence and passionately championing the doctor patient relationship. But there is a shadow side: there is little time to learn new skills. In situations of scarce resources an energetic consultant who puts energy into hospital politics may win at the expense of someone else, and energy and enthusiasm put into the doctor patient relationship may undermine loyalty to the organization. If change is to occur these

strengths and weaknesses must be recognized. The cultural shift has been supported by a clinical directorate management system. Slowly, new skills, looking at costs, and the need to become part of the organization have been recognized. The Americans unlike their UK counterparts have taken things slowly and gone to great lengths to win the support of their clinicians.

If the hospital was the doctors' workshop, as some doctors still think, and the role of other staff, nurses and administrators was to implement doctors' orders with for example sister coordinated nursing, clerical and patient services with other parts of the hospital and if necessary taking over those functions to get things done, then the need for coordination would be reduced but at a cost. The primacy of the individual doctor needs to be replaced by multi-disciplinary teams and a breaking out of tribal groups.

Bennis (1992) stresses the need to overcome divisions and encourage teamwork:

> "There is a need to overcome the divisiveness of structures and there is a recognition of this in the NHS with health authorities attempting to encourage a more corporate spirit of teamwork. All of the best principles of medicine should work in management."

He also recognizes how difficult some of the broader concepts of management can be for doctors:

> "But most doctors have a hard time with management. I've taught a lot of physicians, and nothing in their education has prepared them for the technology of cooperation. They are self absorbed and used to personal intervention rather than working in teams. They don't have the literacy of teamwork, collaboration, and empowering other people."

> "Doctors are socialised in science, to look for the correct answer, to dissect and pull apart, and to make decisions on empirical evidence. They are not educated to be synthetic."

Jarrold (1992) told a forum organised by the Institute of Health Service managers that

> "Learning to change behaviour - from the chief executive through to ward level - is essential if health care organizations are to succeed in meeting the challenges set by the NHS reforms".

He highlighted the areas of greatest need for attention to partnerships including "managers and professionals". Hunter (1992) felt that

"Partnership is about reforming the whole organisation, not bolting it on to others."

He went on to offer a warning however:

"Collaboration is not a panacea and health authorities must work at effective internal partnerships."

Jarrold (1992) felt that:

"The professional is trained to care for the patient. A manager has a wider focus but the two are equal partners. There are faults on both sides but we must all work as a team and demonstrate commitment to patient care, moving from hierarchies to partnerships."

20.2. Directions for Further Work

When I began this project the question I asked seemed simple enough. But it has uncovered many issues and led to a wide range of supplementary questions which are all worthy of investigation in themselves. I have been almost exclusively involved in researching consultants who are actively involved in management in hospitals, but what of the attitudes of those consultants not actively concerned in management?

My work has highlighted the dilemmas that face doctors in management roles. These dilemmas are: doctors are highly motivated but have their own objectives; working hard on patient care but having little time to devote to learning new management skills; doing what they were trained to do as clincians while having to learn and develop new skills; safeguarding the doctor patient relationship at the same time caring for the organization, in other words doing their best for the individual patient while at the same time being aware of the needs of other patients; of too much resource going on one patient due to sheer technical excellence and the advance of technology against the prudent use of resources for the whole community; the dilemma of a restless search for excellence and terchnical advance while being prudent with resources; the feeling of independence, isolation etc., yet now needing to cooperate with others; clinical freedom against central control; and personal medicine as opposed to agency medicine.

Perhaps Hampden-Turner's (1990) methods could be used to identify "both-ands" instead of "either-ors". By identifying and charting key dilemmas and using dual axis and cross axis charting it might be possible to show how to steer a middle course, and to show how far doctors and hospitals have moved in dealing with these issues.

I have mentioned the roles of the Business Manager and Nurse Manager within the directorate but this is a new concept and there is a need to know what is required of their relationship with the Clinical Director.

Clinical freedom is a major issue and is multi faceted. What is the effect of the increasing involvement of doctors in management on clinical freedom and the perception of clinical freedom by patients, managers and doctors? How has the perception changed and what is the nature of the change? How is any change being handled?

What is it about a hospital that causes it to be decentralized or not? Is it the Chief Executive or the Consultants? What is the influence of the Chairman of the Trust Board? What effect do the other executive directors have on the way the hospital is managed?

We have seen how Addison, the first Minister of Health under Lloyd George, and Dawson introduced the idea of an integrated health service with Primary Health Centres in which consultant advice would be available and the hospitals would be Secondary Health Centres. We have seen how further proposals were made to end this separation of the branches of medicine before the formation of the National Health Service. Would uniting the profession in this way, avoiding communication problems, producing a more immediate and coordinated

response between the two, be worth considering again? It is a combination which is being used effectively in some American institutions.

Primary care is taking on more and more of those functions which were hitherto the sole territory of hospitals. Day surgery is increasing but at present is only a fraction of what it will be achieving in the future. The health service is moving towards a need for a more integrated service than ever before. Maybe we are witnessing a return to involving consultants more in patient care outside the hospital again. Perhaps we are seeing the first moves away from the national hospital service towards a truly national health service. When the opportunity for such a revolutionary plan was lost in 1920, Cartwright (1977:166) described the "plan as one of the more important, although tragic, documents in the history of British medicine".

References and Appendix

REFERENCES

Abel-Smith, B. (1964). The Hospitals 1800-1948. London: Heineman Educational Books.

Ackoff, R.L. (1974). Redesigning the Future. New York: Wiley. see also Wilson, R.N. (1959-60).

Appley, L.A. (1969). A Management Concept. New York: American Management Associations. Arrow Books. (First Published by Hutchinson 1967).

Bailey, B. J. (1990). Somehow We Have to Stop the Train Wreck. Archives Otolaryngology and Head and Neck Surgery. Vol 116. June. 669-700.

Batstone, G. (1992). Making Medical Audit Effective. Module 6. Using Audit for Education p.1. London: Joint Centre for Medical Education.

Becker, H S. (1969). Problems in the Publication of Field Studies. In: McCall,G.J. and Simmons, J.L. eds. Issues in Participant Observation: A text and reader. pp.260-276. Reading, Mass.: Addison-Wesley.

Bell, D. (1967). Notes on the Post-Industrial Society. The Public Interest. 6 & 7. (Winter and Spring 1967).

Bell, D. (1972). Labor in the Post-Industrial Society. Dissent 19.1. (Winter). 70-80.

Bennett, G. (1987). The Wound and the Doctor. Secker and Warburg.

Bennis, W. (1992). Leadership and doctors. in Smith, R. Report of meeting of senior managers from NHS at the King's Fund College. British Medical Journal. 305, (18 July). 137-8.

Blau, P.M. and Scott, R.W. (1962). Formal Organizations. pp.189-191. San Francisco: Chandler.

Blumberg, A. (1977). A complex problem - an overly simple diagnosis. Journal of Applied Behavioural Science. 13, 2. 184-189.

Boufford, J.I. (1991). Health Service Journal (20 June), 91.

Boyatzis, R.E. (1982). The Competent Manager. A Model for Effective Performance. New York: Wiley.

Bradbeer, A.F. (1954). The Bradbeer Report. Committee of the Central Health Services Council. The Internal Administration of Hospitals. London: HMSO.

British Medical Association. (1990). CCSC Guidance on Clinical Directorates. May . London: BMA.

Brody, J. (1992). Managing Clinical Services. Decentralisation in Action. International Team Workshop. Conference. London, September 1992.

Bucher, R and Stelling, J. (1969). Characteristics of Professional Organizations. Journal of Health and Social Behaviour. 10, 3-15.

Campbell, D.T. and Stanley, J.C. (1966). Experimental and Quasi-experimental Designs for Research. Chicago: Rand McNally.

Cang, S. (1978). Professionals in Health and Social Service Organizations. In: Jaques, E. ed. Health Services. Chap 5. London: Heinemann.

Carlson, E. (1982). quoted in Peters, T.I. and Waterman, R.H.Jnr. In Search of Excellence. p.122. New York: Harper and Row.

Cartwright, F. (1977). A Social History of Medicine. Harlow. Essex: Longman.

Chantler, C. (1989). How to be a Manager. British Medical Journal. 298, 1505-1508.

Chantler, C. (1990). Management Reform in a London Hospital. In: Carle, N. ed. Management for Health Result. pp.74-86. London: King Edward's Hospital Fund.

Chantler, C. (1991). Personal Communication.

Chantler, C. (1992). Keynote Address. Conference Managing Clinical Services: Decentralisation in Action. London. September 1992.

Chantler, C. (1992a). Managing Clinical Services. Decentralisation in Action. London. September 1992.

Chantler, C. (1992b). Historical Background - where have clinical directorates come from and what is their purpose. Paper prepared for Working Group of the Research Unit, Royal College of Physicians. London. November 1992.

Chantler, C. (1992c). Management and information. British Medical Journal. 304 (7 March), 623-5.

Charlwood, P. (1992). Managing Clinical Services. Centralisation in Action. Conference London. September.

Charns, M.P. (1976). Breaking the Tradition Barrier: Managing Integration in Health Care Facilities. Health Care Management Review. Winter.

Chawner, J. (1991). BMA News Review. 17, (January) 1. 10.

Cox, D. (1986). Implementing Griffiths at the District Level. A Report on Progess. Paper for BSA Med Socio Conference. Birmingham. 1986.

Cox, D. (1990). Health Service Management - a Sociological View or, Griffiths and the Non-Negotiated Order of the Hospital. In: Bury, M. Calnan, M. and Gabe, J. eds. The Sociology of the Health Service. London: Routledge and Kegan Paul.

Cronin, A.J. (1937). The Citadel. London: Gollancz.

Crossmam, R. (1972). A politician's view of health service planning. p. 22. Glasgow: University of Glasgow.

Cummings, T.G and Molloy, E.S. (1977). Improving Productivity and the Quality of Work Life. New York: Praeger.

Daft, R L. (1983). Learning the craft of organizational research. Acad Man Rev., 8, 4. 539-546.

Dalton, M. (1964). Preconceptions and methods in Men Who Manage. In: Hammond, P. ed. Sociologists at Work. New York: Basic Books.

Das, T H. (1983). Qualitative research in organizational behaviour. Journal Management Studies 20, 3. 301-314.

Davis, L.E and Cherns, A.B. eds. (1975). The Quality of Working Life. Volume One: Problems, Prospects and the State of the Art. Volume Two: Cases and Commentary. New York: The Free Press.

Dawe, V. (1992). Profession divided by its system of rewards. Hospital Doctor. 13 February. 33.

Dawson, B. (1920). In: Watkin, B. ed. (1975). Documents on Health and Social Services 1834 to the Present Day. London: Methuen and Co. Ltd.

Devlin, B. (1985a). Second Opinion. Health and Social Services Journal. 7 February. 165.

Devlin, B. (1985b). Second Opinion. Health and Social Services Journal. 18 April. 490.

DHSS. (1972). Management Arrangements for a Reorganised Health Service. London: HMSO.

DHSS. (1972). Report of the Working Party on Medical Administrators. Hunter Report. London: HMSO. 1972.

DHSS. (1972b). Second Report of the Joint Working Party on the Organisation of Medical Work in Hospitals. London: HMSO.

DHSS. (1974). Third Report of the Joint Working Party on the Organisation of Medical Work in Hospitals. London: HMSO.

DHSS. (1979) Patients First. London: HMSO.

DHSS. (1980). Circular HC(80)8 Health Service Development. Structure and Management, July 1980. London: HMSO.

DHSS. (1980). Patients First. A summary of comments received. London: HMSO.

DHSS. (1982). Circular HC(82)1 Health Service Development. Professional Advisory Machinery, January 1982. London: HMSO.

DHSS. (1983). NHS Management Inquiry. Griffiths Report. DA(83)38. London: HMSO.

DHSS. (1986). Health Services Management: Resource Management (Management Budgeting) in Health Authorities Circular HN Health Notice (86) 34. London: HMSO.

DHSS. (1989) Working for Patients. London: HMSO.

Diesing, P. (1972). Patterns of discovery in the social sciences. London: Routledge & Kegan Paul.

Disken, S. Dixon, M. Halpern, S and Shocket, G. (1990). Models of Clinical Management. London: Institute of Health Services Management.

Dixon, M. (1991). In Hey, R. (1991). Code of conduct needed to keep managers in line. Hospital Doctor. 5 December, 28.

Drexler, A. Yenney, S.L. and Hohman, J. (1977). OD An Ongoing Program. Hospitals. 16 February, 89-92.

Drucker, P.F. (1968). The Practice of Management. London: Pan Books.

Druker, P.F. (1977) Management. Tasks, Responsibilties, Practices. 137-147. London: Pan Business Management.

Druker, P.F. (1990). Managing the Non-Profit Organization. New York: Harper Collins.

Drucker, P. (1992). In: Stephany, J. (1992). The Role of Consultant Physicians in Clinical Directorates. Prepared for Working Group of Research Unit of Royal College of Physicians. London.

Earl, M. J. and Skyrme, D.J. (undated). Hybrid Managers. What do we know about them? Research Paper. Oxford Institute of Information Management.

Eddy, D.M. (1990). Clinical decision making: from theory to practice. The challenge. JAMA. 263, 287-90.

Eden, C. Jones, S. and Sims, D.P.B. (1983). Messing about in problems. Oxford: Pergamon.

Elliott, J. (1978). Health Services. London: Heinemann.

Engel, G.V. (1969). The Effect of Bureaucracy on the Professional Autonomy of the Physician. Journal of Health and Social Behaviour. 10, 30-41.

Enthoven, A.C. (1985). Reflections on the Management of the National Health Service. London: Nuffield Provincial Hospitals Trust.

Etzioni, A. (1968). The Active Society. New York: Free Press.

Fitzgerald, L and Sturt, J. (1992). Clinicians into Management. On the Change Agenda or Not? Health Services Management Research. 5, 2, July. 137-146.

Fielding, G.H. (1929). An Introduction to the History of Medicine. 4th ed. Philadelphia: W. B. Saunders Co.

Fisher, D. (1980). A Review of Organization Development. Journal of Nursing Administration. October, 31-36.

Foot, M. (1962). Aneurin Bevan: A Biography. London: MacGibbon & Kee.

Ford, J. (1975). Paradigms and fairy tales (2 vols). London: Routledge & Kegan Paul.

Freidson, E. (1970a). The Profession of Medicine: a Study of the Sociology of Applied Knowledge. New York: Dodd Mead.

Freidson, E. (1970b). Professional Dominance: The Social Structure of Medical Care. Chicago: Aldine Publishing Co.

Friedlander, F. (1976). OD Reaches Adolescence: An Exploration of its Underlying Values. The Journal of Applied Behavioural Science. 12, 1.

Friedman, E. (1991). The Uninsured. Journal American Medical Association. 265 (15 May), 19. 2491-2495.

Galbraith, S. (1991). Chartered Institute of Public Finance and Accountancy Conference. In Health Service Journal. 20 June. 1991.

Gale, R. and Grant, J. (1990). Managing Change in a Medical Context. Guidelines for Action. London: The Joint Centre for Educational Research and Development in Medicine.

Gans, H. (1967). The Levittowners. New York: Pantheon.

Georgopoulos, B.S. (1972). Organization Research on Health Care Institutions. Ann Arbor, Michigan: Institute for Social Research. University of Michigan.

Gioia, D. A. Donnellon, A. and Sims, H.P. (1989). Communication and cognition in appraisal: A tale of two paradigms. Organization Studies. 10, 4. 503-530.

Glaser, B.G. and Strauss, A.L. (1967). The Discovery of Grounded Theory: Strategies for qualitative research. New York: Aldine.

Glaser, B G. (1978). Theoretical sensitivity. San Francisco: Sociology Press.

Gluckman, M. and Devons, E. eds (1964). Closed Systems and Open Minds. Chicago: Aldine.

Golembiewski, R.T. (1969). Organization development in public agengies: Perspectives on theory and practice. Public Administration Review. 29 (July/August), 367-377.

Goode, W.J. (1969). The Theoretical Limits of Professionisation. in Etzioni.

Goss, M. E. W. (1961). Influence and Authority among Physicians in an Out-Patient Clinic. American Sociological Review. 26, 39-50.

Griffiths, R. (1983a). General Observations. Letter to Secretary of State on behalf of NHS Management Inquiry team. 6 October.

Griffiths, R. (1983b). NHS Management Inquiry. London: DHSS.

Griffiths, R. (1991). Audit Commission Annual Lecture by Sir Roy Griffiths 12th June 1991.

Griffiths, R. (1991b). Health Service Journal. 20 June.

Griffiths, R. (1992). Speech to British Association of Medical Managers. 3rd June 1992.

Griffiths, R. (1992b). Who cares? - Management and the caring services. Abridged version of Jephcott Lecture. 21 April 1992. Printed in Journal of the Royal Society of Medicine. 85 (November), 663-8.

Guba, E.G.(1978). Toward a methodology of naturalistic Inquiry in educational evaluation. Monograph 8. Los Angeles: UCLA Center for the Study of Evaluation.

Guba, E.G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. Educational Communication and Technology Journal. 29, 75-92.

Gusfield, J. (1960). Field work reciprocities in studying a social movement. In: Adams, R and Preiss, J, eds. Human Organization Research. Homewood: Dorsey.

Halpern, E.S. (1983). Auditing naturalistic inquiries: The development and application of a model. Unpublished doctoral dissertation. Indiana University. In: Lincol, Y.S. and Guba E.G.(1985). Naturalistic Inquiry. p 319. Clifornia: Sage Publications.

Hampden-Turner, C. (1990). Charting the Corporate Mind: From Dilemma to Strategy. Oxford: Blackwell.

Handy, C.B. (1985). Understanding Organizations. 3rd Ed. London: Penguin.

Handy. C. (1985). Gods of Management. London: Souvenir Press.

Handy, C. (1991). Gods of Management. 3rd Ed. London: Business Books.

Hanlon, M. D. and Gladstein, D.L. Improving the Quality of Work Life in Hospitals. Hospital and Health Services Administration September/October 1984, 94-107.

Harrison, E. F. (1987). The Managerial Decision Making Process. Boston: Houghton-Mifflin.

Harrison, S. (1988). Managing the National Health Service - Shifting the Frontier? London: Chapman and Hall.

Hayek, F.A. (1960). The Constitution of Liberty. p. 300. London: Routledge & Kegan Paul.

Heirs, B. and Farrell, P. (1989). The Professional Decision Thinker. Our New Management Priority. London: Grafton.

Heron, J. (1981). Philosohical basis for a new paradigm. In: P Reason and J Rowan. eds. Human Inquiry. pp.19-35, Chichester: Wiley.

Heron, J. (1989). Validity in Co-operative Inquiry. In: Reason, P. ed. Human Inquiry in Action. Chap 2. London: Sage.

Heron, J. (1988). Validity in co-operative inquiry. In: Reason, P. ed. Human Inquiry in Action: Developments in new paradigm research., pp.40-59, London: Sage.

Heys, R. (1991). Code of conduct needed to keep managers in line. Hospital Doctor. 5 December, 28.

Heyssell, R.M. Gaintner, J.R. Kues, I.W. Jones, A.A. Lipstein, S.H. (1984). Decentralised Management in a Teaching Hospital. The New England Journal of Medicine. 310 (31 May), 22. 1477-1480.

Hickson, D.J. Thomas, M.W. (1969). Professionalisation in Britain, a Preliminary Measurement. Sociology. 3, 1. 37-53.

Higgins, J. (1988). The Business of Medicine. Basingstoke: Macmillan.

HMSO. (1989) Government White Paper. Working for Patients. London: HMSO.

HMSO. (1990). Select Committee on the Parliamentary Commissioner for Administration. Third Report. London: HMSO.

Hocking, J. (1991). Managing in the Market Place: Universities and Insatitutional Change in the Late 1980's and Early 1990's. MBA dissertation, University of Warwick.

Hoffenberg, R. (1987). Clinical Freedom. Rock Carling Lecture. London: Nuffield Provincial Hospitals Trust.

Hoffenberg, R. (1991). The Harveian Oration. Royal College of Physicians. London. 17th October 1991. Transcript p.1.

Holahan, J. Moon, M. Welch, P. and Zuckerman, S. (1991). An American Approach to Health System Reform. Journal American Medical Association. 265 (15 May), 19. 2537-2540.

Honigsbaum, F. (1990). The evolution of the NHS. British Medical Journal. 301 (3 October), 694-9.

Hunt, R. G. Gurrslin, O. and Roach, J. L. (1958). Social Status and Psychiatric Service in a Child Guidance Clinic. American Sociological Review. 23 (1 February) 81-83.

Hunter, R. B. (1972). Report of the Working Party on Medical Administrators. DHSS. London: HMSO.

Hunter, D. (1992). From Hierarchies to Partnerships. In: NHS Management Executive News. 53. (January), 8.

Inglehart, J. K. (1983). The British National Health Service under the Conservatives. New England Journal of Medicine. 309, 1264-68.

Inglehart, J. K. (1984). The British National Health Service under the Conservatives - Part II. New England Journal of Medicine. 310, 63-67.

Illich, I. (1976). Medical Nemisis: The Expropriation of Health. p.46. New York: Phantom Books.

Jacobs, M. O. (1978). Administrators, Boards, Physicians Must Help Change Health System. Hospitals. 52 (1 August) 15. 78-80.

Jaques, E. (1976). A General Theory of Bureaucracy. London: Heineman.

Jaques, E. (1978). Health Services. London: Heinemann.

Jaques. E. (1978). Teams and Leadership. Health Services. p. 141. London: Heinemann.

Jarrold, K. (1992). From Hierarchies to Partnerships. In: NHS Management Executive News. 53 January, 8.

Johnson, T. J. (1972). Professions and Power. London: Macmillan.

Jynton, R. P. (1975). Boundaries in Health Care Systems (Backfeed Section). Journal of Applied Behavioural Science. 11. 2, 250.

Kaluzny, A. D. Hernandez, S. R. (1988). Organizational Change and Innovation, In: Shortell, S.,M. Kaluzney, A. D. eds. Health Care Management: A Text in Organization Theory and Behaviour. 2nd ed. pp.380-81. New York: Wiley.

Kant, I. (1969). In; Blumer, H. Symbolic Interactionism: Perspective and Method. New Jersey: Prentice-Hall.

Kanter, M. R. (1989). When Giants Learn to Dance. London: Unwin Hymans Ltd.

Kennedy, J. F. (1962). In: Lieberman, Tyranny of Expertise. p.5.

Kirby, J. (1991). The hard up story of yesterday's trusts. BMA News Review. 3, 19.

Klein, R. (1983). The Politics of The NHS. Harlow: Longman.

Klein, R. (1985). Who makes the decisions in the NHS? In: NHS Management Perspectives for Doctors. London: King Edward's Hospital Fund.

Klein, R. (1989). The Politics of The NHS. 2nd ed. Longman, Harlow, Essex.

Klein, R. (1990). The State and the Profession: The Politics of the Double Bed. British Medical Journal. 301 (3 October), 700.

Kliny, R. (1992). Managing Clinical Services: Decentralisation in Action. International Perspectives. Conference. London. September 1992.

Kogan, K. et al. (1978). The Workings of the National Health Service. Research Paper No.1 Royal Commission on the NHS. London: HMSO.

Kotter, J. P. (1978). Power, Success, and Organizational Effectiveness. Organizational Dynamics. Americam Management Association. Winter. 27-40.

Kotter, J. P. (1977). Power dependence and effective management. Harvard Business Review. July-August. 125-136.

Kouzes, J. M and Mico, P. R. (1979). Domain Theory: An Introduction to Organizational Behaviour in Human Service Organizations. Journal of Applied Behavioural Science. 15, 4. 449-468.

Ladd, J. (1957). The Structure of a Moral Code. Cambridge: Harvard University Press.

Lane, R. E. (1966). The Decline of politics and Ideology in a Knowledgeable Society. American Sociological Review. 31 October.

Lane, J. (1991). Evaluation of Management Development for Hospital Consultants. Ware: Jack Lane Associates.

Larkin, G. (1983). Occupational Monopoly and Modern Medicine. London, Tavistock.

Lee-Potter, J. (1991). BMA News Review. January, 12.

Leitko, T. A and Szczerbacki, D. (1987). Why Traditional OD Strategies Fail in Professional Bureaucracies. Organizational Dynamics. 15, 52-65.

Levitt, R and Wall, A. (1984). The Reorganised Health Service. 3rd ed. London: Chapman and Hall.

Light, D. W. (1991). Observations on the NHS reforms: an American perspective. British Medical Journal. 303, 568-70.

Lincoln, Y. S. and Guba E. G. (1985). Naturalistic Inquiry. California: Sage.

Llewellyn, K. and Hoebel, E. A. (1941). The Cheyenne Way. Norman: University of Oklahoma Press.

Lofland, J.(1976). Doing Social Life. New York: Wiley.

Loudon, I. S. L. (1979). Trends in General Practice. London: Royal College of General Practitioners.

Loveridge, R. and Starkey, K. eds. (1992). Continuity and Crisis in the NHS: The Polotics of Design and Innovation in Health Care. Buckingham: Open University Press.

Lowry, S. (1992). Student selection. British Medical Journal. 305 (28 November), 1352-4.

Mangham, I. L. (1978). Interactions and interventions in organizations. p.15. Bath: Wiley.

Mannheim, K. (1936). Ideology and Utopia. New York: Harcourt.

Marshall, J. (1981). Making sense as a personal process. In: Reason, P and Rowan, J. eds. Human Inquiry. pp. 395-399, Chichester: Wiley.

Maruyama, M. (1978). Endogenous research: Rationale, Chap 20, and Endogenous research: The Prison Project, Chap 23. In Reason, P and Rowan, J. eds. Human Inquiry. (1981) Chichester: Wiley.

Maslow, A . (1972). Synery in the Society and the Individual. Chap 14 The Farther Reaches of Human Nature. pp.199-211. New York: The Viking Press.

Massarik, F. (1981). The Interviewing process re-examined. In: Reason, P. Rowan, J. eds. Human Inquiry. Chap 17. London: John Wiley.

Maxwell, R. (1992a). Speech at Conference. Managing Clinical Services: Decentalisation in Action. London, September 1992.

Maxwell, R. (1992c). Personal Communication.

Maxwell, R. (1992b). Speech at Workshop Royal College Physicians. London. November 1992.

McClure, L. (1985). Organization Development in the Healthcare Setting. Hospital and Health Services Administration. July/August, 55-64.

Merrison, A. W. (1975). Report of Committee of Inquiry into the Regulation of the Medical Profession. Secretary of State for Social Services. London: HMSO. Cmnd. 6018.

Migue, J. and Belanger, G. (1974). The Price of Health. p.7. Toronto: Macmillan of Canada.

Miles, M. B. (1979). Qualitative data as an attractive nuisance: The problem of analysis. Admin Sci Quarterly. 24, 590-610.

Miles, M. B. (1979). Qualitative data as an attractive nuisance: The problem of analysis. Admin Sci Quarterly. 24, 590-610.

Millar, B. (1991). Clinicians as managers: medics make their minds up. The Health Service Journal. 21 February. 17.

Miller, S. M. (1952). The participant-observer and "over-rapport". American Sociological Review. 17, 97-99.

Mills, I. (1987). Resource Management Feedback. London: DHSS.

Mintzberg, H. (1973). The nature of Managerial Work. New York: Harper and Row.

M.o.H. (1948). Report of the Interdepartmental Committee on the Remuneration of Consultants and Specialists. London: HMSO. Cmnd 7420.

M.o.H. (1967). First Report of the Joint Working Party on the Organisation of Medical Work in Hospitals. London: HMSO.

Morgan, G. (1986). Images of Organization. California and London: Sage.

Mumford, P. (1989). Doctors in the driving seat. Health Service Journal. 612-613.

Musch, K. (1992). Conference Managing Clinical Services - Decentralisation in Action. September. London 1992.

Myrdal, G. (1944). An American Dilemma. Appendix 2. New York: Harper.

Nadler, D. A.and Tichy, N. M. (1982). The Limitations of Traditional Intervention Techniques in Health Care Organizations. In: Marguiles, N. and Adams, J.D. eds. Organizational Development in Health Care Organizations. Reading MA: Addison-Wesley.

Nelson, M. J. (1989). Managing Health Professionals. p.vii. London: Chapman and Hall. London.

NHSTA. (1989). Doctors and Management Development: Policy Proposals from the National Health Service Training Authority. Bristol: NHSTA.

Nichol, D. (1991). BMA News Review. 17 (January), 1.10.

Pater, J. E. (1981). The Making of the National Health Service. London: Kings Fund.

Pellegrino, E. D. (1990). The Relationship of autonomy and integrity in medical ethics. In: Allebeck, P. Jansson. B. eds. Ethics in medicine. New York: Raven Press.

Pellegrino, E. D. (1972). The Changing Matrix of Clinical Decision-Making in the Hospital. In: Georgopoulis, B. S. ed. Organization Research on Health Care Institutions. chap 13. Michigan: Institute for Social Research. The University of Michigan.

Perros, C. (1978). Complex Organizations. Glenview: Foresman.

Perrow, C. B. (1961). Organizational Prestige: Some Functions and Dysfunctions.American Journal of Sociology 66 (January), 4. 335-341.

Perrow, C. B. (1980). "Zoo Story" or life in the organizational sandpit. In: Salaman, G and Thompson, K. eds. Control and ideology in organizations. Milton Keynes: Open University Press.

Perucci, R. (1973). Engineering: Professional servant of power. In Friedson, E. ed. Professions and Their Prospects. London: Sage.

Petchey, R. (1986). The Griffiths Reorganisation of the NHS Fowerlism by Stealth? Critical Social Policy. 87-101.

Pettigrew, A. Ferlie, E. and McKee, L. (1992). Shaping Strategic Change. Making Change in Large Organizations. The Case of the NHS. London: Sage.

Phillips, D. C. (1985). After the Wake: postpositivistic educational thought. Educational Researcher. 12, 4-12.

Plovnick, M. S. (1982). Structural Interventions for Health Care Systems Organizational Development. Organizational development. In: Margulies, N and Adams, J.D. eds. Health Care Systems. Reading MA: Addison-Wesley.

Pollitt, C. Harrison, S. Hunter, D. and Marnoch, G. (1988). The Reluctant Managers: Clinicians and budgets in the NHS. Financial Accountability & Management. 4, 3 (Autumn). 213-233.

Pope, C. (1991). Trouble in store: some thoughts on the managementy of waiting lists. Sociology of Health and Illness. 13, 193-212.

Pouvourville, G. de. (1989). Differences in the Approaches of the Doctor, Manager, Politician and Social Scientist in Health Care Controversies - Hospital Case-mix Management Methods: An Illustration of the Manager's Approach in Health Care Controversies. Social Science Medicine. 29, 3. 341-9.

Rapoport, R. N. (1970). Three dilemmas of Action Research. Human Relations. 23, 6. 499-513.

Reason, P and Rowan, J. (1981). Human Inquiry. Issues of Validity in New Paradigm Research. Chicester: Wiley.

Redfield, R. (1960). The Little Community. Chicago: University of Chicago and Myrdal.

Reich, C. A. (1970). The Greening of America. How the Youth Revolution is Trying to Make America Liveable. New York: Randon House.

Resource Management Feedback. (1987). The Resource Management Initiative. Issue No.1, August 1987.

Rosen, G. (1972). In: Guest, R. The role of the doctor in institutional management. In Georgopoulos, B. S. ed. Organizational Research on Health Management Michigan: Institute for Social Reseach, University of Michigan.

Rowbottom, R. W. (1978). Professionals in Health and Social Services Organizations. In: Jacques, E. ed. Health Services. chap 5. London: Heinemann.

Rowbottom, R. W. et al. (1973). Hospital Organization. chap 9. London: Heinemann.

Rowbottom, R. W. (1978). Professionals in Health and Social Service Organizations. In: Jacques, E. Health Services. chap 5. London: Heinemann.

Rubin, I. Plovnick, M. and Fry, R. (1974). Initiating planned change in health care systems. The Journal of Applied Behavioural Science. 10, 1. 107-124.

Rubin, I. Plovnick, M. and Fry, R. (1977). The Role of the consultant in initiating planned change: A case study in health care sysatems. In: Burke, W. W. ed. Current issues and strategies in organization development. New York: Human Sciences Press.

Russell, B. (1958). Portraits from Memory. London: Allen & Unwin.

Sanford, N. (1981). A Model for Action Research. In: Reason, P and Rowan, J. eds. Human Inquiry. pp.373-381. Chichester: Wiley.

Sayles, L. R. (1964). Managerial Behaviour. Administration in Complex Organization. New York: McGraw-Hill.

Schneller, E.S. and Weiner, T.S. (1985). The MD -JD revised. A sociological analysis of the cross-educated professionals in the decade of the 1980s. The Journal of Legal Medicine. 6, 3. 337-372.

Schon, D. A. (1983). The Reflective Practitioner. How Professionals Think in Action. Vermont: Gower. Paperback (1991). Aldershot: Academic Publishing Group.

Schulz, R. and Harrison, S. (1983). Teams and Top Managers in the NHS, A Survey and Strategy. No 41. London: Kings Fund Centre Project Paper.

SCOPME. (1990). Medical Audit - Educational Implications. London: SCOPME.

Scott, W. R. (1965). Reactions to Supervision in a Heteronomous Professional Organization. Administrative Science Quarterly. 10, 65-81.

Scriven, M. (1971). Objectivity and subjectivity in educational research. In Thomas, L.G. ed. Philosophical redirecrtion of educational research (71st Yearbook of the National Society for the Study of Education, part 1). Chicago: University of Chicvago Press.

Scrivens, E. (1988). Doctors and Managers: never the twain shall meet? British Medical Journal. 296, 1754-5.

Scwartz, P. and Ogilvy, J. (1980). The emergent paradigm: changing patterns of thought and belief. Analytical Report No 7, Values and Lifestyles Program. California: SRI International.

Shields, R. and Leinster, S.J. (1993). Position Paper on Clinical Directorates A Guide for Surgeons. Edinburgh: Royal College of Surgeons of Edinburgh.

Shortell, S.M. Morrison, E.M. and Friedman, B. (1990). Strategic Choices for America's Hospitals. San Francisco: Jossey Bass.

Simendinger, E. A. Pasmore, W. (1984). Developing Partnerships Between Physicians and Healthcare Executives. Hospital and Health Services Administration. 29 (Nov/Dec), 21-35.

Sims, D. B. P. (1981). From ethogeny to endogeny: how participants in research projects can end up doing research on their own awareness. In: Human Inquiry. Reason, P and Rowan, J. eds. chap 32. Chichester: Wiley

Sims, D. B .P. (1987). From Harmony to Counterpoint. Organization Analysis and Development; A Social Construction of Organizational Behaviour. In: Mangham, I. L. ed. Organization Analysis and Development. Chichester: Wiley.

Skynner, A. C. R. (1976). One Flesh: Separate Persons. Principles of Family and Marital Psychotherapy. London: Constable.

Smith, G. W. (1984). Towards an Organisation Theory for the NHS. Health Services Manpower Review. 3-7.

Smith, H. L. (1958). Two Lines of Authority: The Hospital's Dilemma. In: Jaco, E.G. ed. Patients, Physicians and Illness. pp 468-477. New York. The Free Press.

Speller, S. R. (1971). Law Relating to Hospitals and Kindred Institutions. 5th ed. pp.150-1.

Stewart, R. (1986). Involving Doctors in GM. Templeton Series. Paper No 5. Bristol: NHSTA.

Stewart, R. (1967). Managers and Their Jobs. London: Macmillan. And in Contracts in Management. London: McGraw-Hill.

Stewart, R. (1982). Choices for the Manager. Maidenhead: McGraw-Hill.

Stewart, R and Dobson, S. (1988). Griffiths in Theory and Practice: A Research Assessment. The Journal of Health Administration Education. 6, 3. 503-514.

Strong, P. and Robinson, J. (1990). The NHS - Under New Management. Milton Keynes: Open University Press.

Sumners, J.W. (1981). Money Health and The Health Care Industry. Hospital and Health Services Administration. Winter. 7-24.

Susman, G. I. and Evered, R. D. (1978). An Assessment of the scientific merits of Action Research. Admin Sci Quarterly. 23, 582-603.

Templeton Series on DGM's Issue Study 5. (1986). Managing with doctors. Working together? NHS Training Authority. Aldershot: The Academic Publishing Group.

Thome, C. (1991). Chartered Institute of Public Finance and Accountancy Conference in June 1991. Reported in Health Service Journal. 20 June 1991.

Thompson, D. (1987). Coalitions and Conflict in the NHS, some implications for management. Sociology of Health and Illness. 9, 2. 125-53.

Thompson, J. D. (1972). Organizations in Action. New York: McGraw-Hill.

Toghill, P. J. (!992). Merit Awards. Hospital Update Plus. October. pp 140-142.

Tolliday, H. (1978). Clinical Autonomy. In: Jaques E. ed. Health Services. chap 4. London: Heinemann.

Tomlinson, B. (1992). Report of the inquiry into London's health services, medical education and research. London: HMSO. (The Tomlinson Report).

Toynbee, P. (1977). Hospital. Chap 6. Consultant. London: Hutchinson.

Turrill, T. Wilson, D. and Young, K. (1991). The Characteristics of Excellent Doctors in Management. NHS Management Executive, Resource Management Unit. Thirsk: Turrill.

Vidich, A. and Bensman, J. (1960). The validity of field data. In: Adams, R. and Preiss, J. eds. Human Organization Research. Homewood: Dorsey.

Vinter, R. D. (1959). The Structure of Service. In: Kahn, A. J. ed. Issues in American Social Work. pp.260-65. New York: Columbia University Press.

Vinter, R. D. (1963). Analysis of Treatment Organizations. Social Work. July, 3-15.

Warden, J. (1991). The Manager is King. British Medical Journal. 302, 1 June. 1298.

Wax, R. (1960). Reciprocity in field work. In: Adams, R. and Preiss, J. eds. Human Organization Research. Homewood: Dorsey.

Weber, M. (1947). The Theory of Social and Economic Organization. London: Oxford University Press.

Weisbord, M. R.(1976). Why Organization Development Hasn't Worked (So Far) in Medical Centers. Health Care Management Review. Spring, 17-28.

Weisbord, M. R. and Stoelwinder, J. U. (1979). Linking Physicians, Hospital Management, Cost Containment and Better Patient Care. Health Care Management Review. 4, 2.

Welborne, I. W. B. (1990). The Management of Change. British Journal of Hospital Medicine. 44, July. 53-55.

West, P. A. (1988). Understanding the NHS: A question of incentives. p.99. London: King Edwards Hospital Fund.

White, A. (1991). Lecture at Resource Management for Doctors Course, Kings Fund College. 10th December 1991.

White, A. (1992b). Making Medical Audit Effective. Module 7. Achieving Change through Audit. p.20. London: Joint Centre for Medical Education.

White, A. (1992c). Management for Clinicians. Chap 5. London: Edward Arnold.

Wilensky, H. L. (1964). The professionalisation of everyone? American Journal of Sociology. 70, 137-58

Williams, A. (1985). Medical Ethics: Health Service Efficiency and Clinical Freedom. Nuffield/York Portfolio No.2. London: Nuffield Provincial Hospitals Trust.

Wilson, N. (1946). Municipal Health Services. London: Allen and Unwin.

Wilson, R. N. (1959-60). The Physician's Changing Hospital Role. Human Organization. 18, 177-183.

Winkenwerder, W. and Ball, J. R. (1988). Transformation of American Health Care. The role of the medical profession. New Engl. J. Med. 1988. 318. 317-9.

Wraith, M. Casey, A. (1992). Implementing Clinically Based Management. Getting Organisational Change Underway. Wraith Casey. in conjunction with The Resource Management Unit of the NHS Management Executive. London: NHSME.

Wraith, M. and Casey, A. (1992b). New Management in Evolution. Droitwich: Wraith Casey.

Zander, A. F. Cohen, A. R. and Stotland, E. (1957). Role Relations in Mental Health Professions. Chap 4. Michigan: University of Michigan Press.

APPENDIX

GLOSSARY OF ABBREVIATIONS

AHA	Area Health Authority
ATO	Area Team of Officers
BMA	British Medical Association
BoG	Board of Governors
CE	Chief Executive
CEO	Chief Executive Officer
CD	Clinical Director
CHC	Community Health Council
CCSC	Central Consultants and Specialists Committee
CCT	Clinical Care Team
CNO	Chief Nursing Officer
COO	Chief Operating Officer
CP	Community Physician
CST	Clinical Service Team
DA	District Administrator
DCP	District Community Physician
DGH	District General Hospital
DGM	District General Manager
DHA	District Health Authority
DHMC	District Hospital Medical Committee
DHSS	Department of Health and Social Security
DMB	District Management Board
DMC	District Medical Committee
DMO	District Medical Officer
DMT	District Management Team
DMU	Directly Managed Unit
DNO	District Nursing Officer
DPG	District Policy Group
DPT	District Planning Team
DTO	District Team of Officers
ECR	Extra Contractual Referral
FPC	Family Practitioner Committee
GMC	General Medical Council
GNC	General Nursing Council
GP	General Practitioner
HA	Health Authority
HAS	Health Advisory Service
HC	Health Care
HCPT	Health Care Planning Team
HCT	Health Care Team
HMAC	Hospital Medical Advisory Committee
HMC	Hospital Management Committee
HMSO	Her Majesties Stationary Office
JCC	Joint Consultative Committee
JCPT	Joint Care Planning Team
LHC	Local Health Council
LMC	Local Medical Committee
MPC	Medical Practices Committee
MAC	Medical Advisory Committee

MEC	Medical Executive Committee
MoH	Ministry of Health
MSC	Medical Staff Committee
NAHA	National Association of Health Authorities
NAO	National Audit Office
NHS	National Health Service
NHSTA	National Health Service Training Authority
OD	Organizational Development
PESC	Public Expenditure Survey Committee
PH	Public Health
RAWP	Resource Allocation Working Party
RCP	Royal College of Physicians
RCN	Royal College of Nursing
RCS	Royal College of Surgeons
RHA	Regional Health Authority
RHB	Regional Hospital Board
RMI	Resource Management Initiative
RMO	Regional Medical Officer
RTO	Regional Team of Officers
UGM	Unit General Manager
UMB	Unit Management Board
UMT	Unit Management Team